S. HRG. 101-566, PT. 2

HEALTH CARE FOR THE UNINSURED

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

FEBRUARY 15, 1990 (WARREN, MI)
APRIL 18, 1990 (WASHINGTON, DC)

(Part 2 of 2)

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
33-411 WASHINGTON : 1990

S361-48

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

SPARK M. MATSUNAGA, Hawaii [1]
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, Jr., Michigan
JOHN D. ROCKEFELLER IV, West Virginia
TOM DASCHLE, South Dakota

BOB PACKWOOD, Oregon
BOB DOLE, Kansas
WILLIAM V. ROTH, Jr., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
DAVE DURENBERGER, Minnesota
WILLIAM L. ARMSTRONG, Colorado
STEVE SYMMS, Idaho

VANDA B. MCMURTRY, *Staff Director and Chief Counsel*
EDMUND J. MIHALSKI, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH FOR FAMILIES AND THE UNINSURED

DONALD W. RIEGLE, Jr., Michigan, *Chairman*

BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
JOHN D. ROCKEFELLER IV, West Virginia

JOHN H. CHAFEE, Rhode Island
WILLIAM V. ROTH, Jr., Delaware
DAVE DURENBERGER, Minnesota

---

[1] NOTE: Senator Matsunaga passed away on April 15, 1990. He was replaced on the Committee by Senator John Breaux from Louisiana.

CONTENTS

THURSDAY, FEBRUARY 15, 1990

Opening Statement

Page

Riegle, Hon. Donald W., Jr., a U.S. Senator from Michigan, chairman of the subcommittee 1

Committee Press Release

Finance Subcommittee on the Uninsured to Hold Hearing in Michigan 1

Public Witnesses

Nunnally, Luann E., Woodhaven, MI 7
Dilloway, David and Arlene, Lapeer, MI 11
Robinson, Eli E., president, Southfield City Council, Southfield, MI 15
Hochbaum, Solomon, Dr., chairman, department of emergency medicine, Sinai Hospital, Detroit, MI 19
Yellan, Robert J., vice president, Governmental and Regulatory Affairs, the Detroit Medical Center, Detroit, MI 25
Benfer, David W., executive vice president, Henry Ford Hospital and group vice president, Henry Ford Health System, Detroit, MI 30
Maher, Walter B., director, Federal relations, Human Resources Office, Chrysler Corporation 35
Lathrop, Bob, political and legislative director, Michigan State Council, Service Employees International Union, AFL-CIO, CLC 39
Grubb, Jerry, Michigan Association of Ambulance Services, Bloomfield Hills, MI 45
Howell, Delores, president, Alliance of the Mentally Ill of Michigan, Oakland County, MI 46
Gifford, Ruth, Oakland County Association for the Mentally Ill, Oakland County, MI 47
Bianchini, Gus, chairman, Warren Seniors, Warren, MI 48
Skowronek, Jackie, Alpena, MI 49
Malley, Mike, placement coordinator, Rainbow Tree Center, Ypsilanti, MI 54
Kerr, Marvin 58
Koman, Jo Ann, Roseville, MI 59

WEDNESDAY, APRIL 18, 1990

Opening Statements

Riegle, Hon. Donald W., Jr., a U.S. Senator from Michigan, chairman of the subcommittee 61
Chafee, Hon. John C., a U.S. Senator from Rhode Island 63
Rockefeller, Hon. John D., IV, a U.S. Senator from West Virginia 64
Durenberger, Hon. David, a U.S. Senator from Minnesota 65
Bentsen, Hon. Lloyd, a U.S. Senator from Texas, Chairman, Senate Finance Committee 66

Committee Press Release

Finance Subcommittee to Hold Hearing on Health Insurance and Health Care Problems 61

Page

Congressional Witness

Kennedy, Hon. Edward M., a U.S. Senator from Massachusetts 67

Public Witnesses

Dukakis, Hon. Michael S., Governor, State of Massachusetts 69
Diprete, Hon. Edward D., Governor, State of Rhode Island 72
Wilensky, Gail R., Ph.D., administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, DC 89
Hungate, Robert W., government affairs, health care, Hewlett-Packard, Washington, DC 104
Maher, Walter B., director, Federal relations, Human Resources Office, Chrysler Corporation, Washington, DC 107
Roush, Michael, assistant director, Federal Government relations, Senate, National Federation of Independent Business, Washington, DC 109
Hoffman, William S., Ph.D., director, Social Security department, international union, United Automobile, Aerospace and Agricultural Implement Workers of America (United Auto Workers), Detroit, MI 110

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

Babcock, C. Patrick:
    Prepared statement 127
Benfer, David W.:
    Testimony 30
    Prepared statement 130
Bentsen, Hon. Lloyd:
    Opening statement 66
    Prepared statement 133
Bianchini, Gus:
    Testimony 48
Chafee, Hon. John H.:
    Opening statement 63
Dilloway, Arlene and David:
    Testimony 11
    Prepared statement 133
Diprete, Hon. Edward D.:
    Testimony 72
    Prepared statement 134
Dukakis, Hon. Michael S.:
    Testimony 69
    Prepared statement 136
Durenberger, Hon. David:
    Opening statement 65
Eichler, Luann:
    Testimony 7
    Prepared statement 166
Gifford, Ruth:
    Testimony 47
Grubb, Jerry:
    Testimony 45
Hochbaum, Solomon:
    Testimony 19
    Prepared statement 141
Hoffman, William:
    Testimony 110
    Prepared statement 141
Howell, Delores:
    Testimony 46
Hungate, Robert W.:
    Testimony 104
    Prepared statement 146
Kennedy, Hon. Edward M.:
    Testimony 67
    Prepared statement 150
Kerr, Marvin:
    Testimony 58

Page

- Koman, Jo Ann:
  - Testimony 59
- Lathrop, Bob:
  - Testimony 39
  - Prepared statement 152
- Maher, Walter B.:
  - Testimony 35, 107
  - Prepared statements 154, 163
- Malley, Mike:
  - Testimony 54
- Renaud, Carol:
  - Prepared statement 167
- Riegle, Hon. Donald W., Jr.:
  - Opening statement 1, 61
  - Prepared statement 168
- Robinson, Eli E.:
  - Testimony 15
  - Prepared statement 170
- Rockefeller, Hon. John D., IV:
  - Opening statement 64
- Roush, Michael:
  - Testimony 109
  - Prepared statement 171
- Skowronek, Jackie A.:
  - Testimony 49
- Smith, Vernon K.:
  - Prepared statement 178
- Wilensky, Gail R.:
  - Testimony 89
  - Prepared statement 180
- Woodbury, Gary M.:
  - Prepared statement 183
- Yellan, Robert J.:
  - Testimony 25
  - Prepared statement 185

COMMUNICATIONS

- Aetna Life Insurance Company 188
- American Psychiatric Association, et. al 192
- CRS Report for Congress 206
- General Motors Corporation 222
- Griffin, E. Frank 226
- Health Policy Coalition 234
- Kulchitsky, Roman 244
- Macomb County Community Services Agency 265
- Michigan Association of Ambulance Services 246
- NFIB Foundation 247
- Southeast Michigan Hospital Council 304
- U.S. Small Business Administration 304
- Wayne County, Office of Health & Community Services 265

HEALTH CARE FOR THE UNINSURED

THURSDAY, FEBRUARY 15, 1990

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Warren, MI.

The hearing was convened, pursuant to notice, at 10:11 a.m., at the Ukrainian Cultural Center, Warren, MI, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: David Krawitz, Administrative Assistant; Debbie Chang, Legislative Aide.

[The press release announcing the hearing follows:]

[Press Release No. H-8, Feb. 8, 1990]

FINANCE SUBCOMMITTEE ON THE UNINSURED TO HOLD FIELD HEARING IN MICHIGAN

WASHINGTON, DC.—Senator Donald W. Riegle, Jr., (D., Michigan), Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, announced Thursday that the Subcommittee will hold a field hearing in Warren, Michigan next week to explore options for providing coverage to uninsured people and hear witnesses' comments on specific proposals that Senator Riegle is developing.

The hearing is scheduled for *Thursday, February 15, 1990 at 10 a.m.* at the Ukrainian Cultural Center, 26601 Ryan Road, Warren, Michigan.

Senator Riegle said, "I am holding this hearing to hear the views of Michigan citizens on a variety of proposals I have been developing to ensure health care coverage for all Americans."

"As Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, my top priority is to see that all Americans have health care coverage," he said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. Let me invite everyone to come on into the room. Although this is a formal hearing today, which I will describe in a minute, we will proceed in a less formal manner, in a more intimate manner. The weather, obviously, has been very difficult for people to deal with. We have had a large number of people call us who told us that they were planning to come and participate, or to come and listen, but were coming from far enough away that the weather just was too difficult for them.

So we will be sending those people that contact us, copies of the record of this hearing today when it is ready, so that they will be able to participate in that forum.

I want to say to our witnesses who are present that we had ten witnesses scheduled for today. Seven of those ten are present in the room. I want to congratulate all of you and thank you for your determination to brave the elements and to be present this morning. There is a lot of feeling and purpose in what brings us together. That will become apparent as the morning goes forward.

So I want people to feel relaxed in the room. We have coffee in the back. We have some doughnuts and rolls in the other room where our witnesses were gathering. I want people to feel free to move around and be comfortable this morning and have coffee and be prepared to share with us their thoughts at an appropriate time.

I have an opening Statement that I want to go through before we get to our witnesses. I want to begin by thanking the Ukrainian Cultural Center for their great hospitality, again, in affording us the opportunity to use this location, this wonderful meeting room and all the help that they have provided.

I knew in the middle of last night when the snow was coming down, and the freezing rain, that despite all that, the flags would be flying here this morning bright and early at the Ukrainian Cultural Center and the driveway would be shoveled out. And sure enough, it was. We thank everyone involved for their help in letting us use this location and having it ready for us this morning.

This is an official hearing of the Senate Finance Committee Subcommittee on Health for Families and the Uninsured. I serve as the Chairman of that Subcommittee. We see ourselves, that Subcommittee, as having the responsibility for leading the effort, the legislative effort in the United States Senate to produce a new manner of health insurance coverage that can reach every citizen in our society.

Today, we are going to be hearing the views of a variety of Michigan citizens and experts on proposals that we are considering in the United States Senate to solve the problem of the 37 million American citizens today who have no health insurance.

Tragically, 12 million of that group are children who, in many instances, are the most vulnerable members of our society. Right here in Michigan, we have over one million people with no health insurance at all, and close to 300,000 of that group are children.

Last year, this Subcommittee held a hearing in Southfield—someof you were present at that hearing—to begin the systematic examination in a public hearing forum of the problems of people who have no health insurance coverage. On that day on which the weather was much more cooperative, over 400 people attended that hearing to present and hear testimony from uninsured people, from business and government leaders and health providers.

We have taken that information and that body of testimony, and we have used it to make very substantial progress since that time. Today, we are here to take a further step based on the work that was done then and since. I might say with the turn-out that we had then, and based on the early indications that we had today that but for the blizzard conditions outside, we would have a very substantial turn-out of people here today. And so I don't think we can judge the dimension of the public interest by crowd size alone, given the weather conditions. But this is an urgent issue, and those of us that are here today who come from various places are here because that is so.

With the information that we will be gathering today and in conjunction with our previous hearing and other hearings that we are conducting in Washington, I believe we are well on our way toward developing a comprehensive legislative solution to this tragic problem of people who do not have health insurance. In the Senate, I have organized a bipartisan Senate working group with twelve Senators representing the Senate Finance Committee and the Senate Labor and Human Resources Committee, because we share jurisdiction on these health issues, to have this working group develop legislation to resolve, the problems of Americans without health insurance.

This type of effort between the two major committees on health is unprecedented. The bipartisan working group in the Senate includes key Senate health policy experts; Senators Kennedy, Senator Mitchell, Senator Durenberger, Senator Hatch and many others.

Just ten days ago we had a meeting that lasted over an hour with ten of those Senators present in my office in Washington. We made good progress in that meeting. We have actually been working on the problem for the past eight months on what can be thought of as a combination private and public sector solution that will provide health care access for all Americans.

Our working group will be releasing a document for public comment in the month of March, just after the formal recommendations of the Pepper Commission are released. The Pepper Commission is an official body that has been working for some time on the question of meeting health care needs in the country particularly, long-term health care needs for seniors. They are very close to completing their work and making their findings public.

Once they have done so, we will put our formal set of ideas on the table for broad national comment and review.

Insofar as the Subcommittee that I am chairman of and that hosts this hearing today, it is my intention to move this legislation this year. I think we are ready to do it' and therefore, we intend to and we appreciate and will need and use the help of all of you in the room to that end.

The purpose of our hearing today is to give Michigan citizens the opportunity to react to a variety of proposals that are under consideration. I will share your input with the Senate working group that I just described so that you will have an opportunity to be a part of the evaluation process that we are concluding.

We are here, to get that kind of reaction and feeling at this stage of the work. Some very important witnesses are going to testify today. The individuals who are testifying here, and who testified at our Southfield hearing, will bring us up to date on the situation as they see it. We will also hear from government and business experts, as well as providers. I welcome others to submit their testimony in writing, or orally to my staff. All such testimony, whether given to us today or, in light of the weather, after today, will be incorporated and made a part of the official transcript of the hearing.

Just a few more thoughts by way of setting the stage for our hearing discussion today. As most of you know, the United States has the highest per capita health care spending of any country. We spend over $1,900 per person on health care each year in the United States. In total, U. S. spending on health, a figure of in excess of $660 billion, is approaching 12 percent of our entire gross national product, far exceeding that of any other nation in the world. So we are spending plenty of money on health care in the United States, however one measures it.

Yet we have a very uneven pattern of who gets health care protection, as illustrated by the earlier figures. One million people in Michigan alone have no health insurance whatsoever. High costs for health care and health care insurance have forced families to absorb higher out-of-pocket costs because of cutbacks in employer-provided health care benefits. This leads many people to question whether we are getting appropriate value for this massive financial investment.

At the same time, there are ever growing and pressing needs. There are around 37 million people who have no health insurance and some 14 million who do not even seek care that they need because they know they cannot afford it.

In addition, uncompensated care costs, over $8 billion; drives up costs for everyone and is very disruptive and threatening to our entire health care system. In fact, later today, we are going to visit the emergency room of a hospital in this area that is being swamped by cases that they must handle on an emergency basis where the people come in and don't have the ability to pay. The hospital is dealing as best it can with providing emergency help on the one hand but going deeper and deeper in debt on the other hand. This is a pattern that we are seeing in many, many hospitals throughout Michigan and across the country.

Obviously, this can't go on indefinitely without these hospitals being put into financial bankruptcy or in some cases, being forced to face the prospect of having to close.

So the spillover of this problem, both in people's lives and into the institutional settings where health care is given, is at the danger point in many areas. We know that uninsured people are found in all age groups, and all employment statuses. Many of our uninsured are people who work each day and have jobs and in a wide variety of income levels.

Many people are falling through the cracks of our employment based system of health care. In fact, two-thirds of all uninsured people are employed individuals and their family members. Medicaid, the program for low-income people, is also inadequate. Over one-third of the uninsured are poor. Medicaid covers only 48 percent of people below the poverty line. Our system of public and private programs leaves huge gaps in coverage that indicate what I consider to be a radical maldistribution of resources.

You take this huge spending on the one hand per capita and in terms of the total percentage of our gross national product and then this very inadequate matter of coverage on the other hand. Clearly, the system is not working the right way. It must be changed and made to work.

I want to also raise another issue that I know one of our witnesses will talk about today, and that is that increasingly, this inefficiency is creating an enormous economic effect on our international competitiveness.

We are finding, for example, that companies that provide health care for their workers, as we would like all companies to do, are finding that the costs for providing the health care coverage are going through the roof. As a result, the cost of production and the cost of the products produced by those companies are becoming less and less competitive economically in the world marketplace.

We will hear from Chrysler Corporation this morning. They have given us information that indicates that just a year ago in terms of their U.S. production costs per car, that the cost of health insurance for current workers and retired workers was about $700 a car; $700 a car is the cost just for the health insurance protection.

If you compare the health insurance costs to build a car in other countries—Canada, France, Germany and Japan—the health care costs that are built into the price of cars is much less by several hundred dollars per car. So we have almost a $500 excess cost, with respect to Canada, which is across the Detroit River. The Chrysler Corporation's health care costs per car in the United States are nearly $500 higher than in Canada for Chrysler cars produced there.

That is not an uncommon situation. We are increasingly having all types of companies that provide health care coverage say we need a change the system. We will hear their formal testimony later.

So from an economic point of view in terms of the cost of production and world competition, and from the point of view of having a healthy work force, we must change the system to see to it that everyone is brought in under a reasonable and solid health insurance system that meets their needs.

I had some charts that I was going to go through, but because of the weather the staff member could not get over the roads to bring them. We have some in the press packets back here for the press members who are present, and we have distributed copies to our witnesses. We will also provide copies to those of you that request them.

The five charts that we have show the variety of initiatives that we are examining to expand private sector health care coverage. One part of the answer to the problem will be to help private employers broaden coverage, both big business and small business, beyond what we presently see.

A lot of workers, have no health insurance at the work site. We would like to increase that to the maximum extent possible. We think there are ways to do that with positive incentives and other constructive measures.

Obviously, we need to take into account the fact that some special provisions will have to be put in place for small business, because there is a smaller pool of workers. The insurance situation tends to be different with a smaller risk pool. So small business faces some problems that require special attention and special answers. We intend to help provide those.

We also need broader public coverage. The Medicaid program can be broadened; needs to be broadened. We have to go to a higher dollar figure in terms of a level of poverty income or income above the poverty level and stretch out a certain amount of health care coverage in that forum.

Then finally, we are going to need some additional insurance pools. There is debate as to whether they should be done within local areas or within States and how the State, local and Federal governments would work together to help do this. To pick up the remaining people without health insurance, we will need to craft a public program with an insurance pool where people keep everyone, would be able to participate on a sliding scale based on their ability to pay.

Obviously, someone that can't pay very much would pay less. Someone who can afford to pay more would do so for the same coverage. The premise would be that every American should have access to health care that preserves their health; that this is essential to the future of the country; that that is a basic principle of fairness in this society, and it is a basic requirement of our country.

We are spending the money now. We are not getting the kind of value that we need to. By rearranging some things, I think we can solve this problem.

Just one other thing: That is that we have got to have cost containment at the same time. We must put some new disciplines in the system so we do not waste money; that we get medical procedures that we need; that procedures are fairly priced; that we do not get expensive and unnecessary procedures that balloon the cost and in fact, not improve health.

There has to be a serious effort at rationalizing the system and providing a structure of cost containment and cost efficiency. At the same time we must broaden coverage so that there is health care for those in need, but not waste money by creating a situation where unwarranted enormous private gain comes out of the system.

President Bush mentioned the other night in the State of the Union Message that he was now seeing this as a major priority for the country and that he wanted all of the studies and ideas looked at again and reviewed. I don't know whether he had in mind bringing forward a legislative initiative this year, but I do. And we are going to bring one forward. The general outlines of that will be what we discuss here today.

Let me move to our witness list. We will have three panels. Ten witnesses were scheduled today, seven of whom are present. Three were not able to come because of the distance and the weather. The comments of the remaining three will be included in the record.

The first witness we have today is a very important one, very important for many reasons. Luann Nunnally from Woodhaven, who is going to testify first on our citizen panel, is the sister of Cheryl Eichler. Those of you who were at our hearing several months ago will remember Cheryl, because she left the hospital on the date of the hearing to come to testify about the problems that she had experienced. In all my years in the Congress, now numbering 24, I don't know that I have ever heard a witness provide more important, compelling testimony or more courageous testimony than Cheryl did that day. She is very special.

Cheryl was truly heroic to come and tell her story. That was in June of last year. I am deeply saddened to say that Cheryl passed away last October. She had had Crohn's Disease for thirteen years.

I am very much of the view that her life could have been different. Probably she would still be with us, if she had been able to receive the kind of immediate medical care throughout her illness that many times she was not able to obtain because she lacked health insurance.

So we have asked Luann to testify today and share with us the rest of this story. When she finishes, I am going to comment. She has others with her today that I will acknowledge later.

STATEMENT OF LUANN EICHLER NUNNALLY, WOODHAVEN, MI

Senator RIEGLE. Luann, I know this is not an easy subject for you to talk about, but you are with a lot of people here today who love you. Why don't you take a deep breath and pull that microphone over there a little bit closer and share your testimony with us.

Mrs. NUNNALLY. My name is Luann Nunnally. I am the sister of Cheryl Eichler. Cheryl was a witness at the Senate Finance Subcommittee hearing on the uninsured held on June 28, 1989 in Southfield, Michigan. I have been asked to testify on her behalf.

Cheryl had Crohn's Disease for thirteen years. She was first diagnosed as having Crohn's disease in 1976 when we lived in Florida. When we moved back to Michigan in 1977, Cheryl was admitted to Wayne County General; that is when she had her first surgery and the doctors removed part of her colon. She was in the hospital for 3 months at that time.

Luckily, our mother was receiving assistance through the Aid for Dependent Children program, and because of this Medicaid, Cheryl was able to survive her first battle with Crohn's.

In 1982 , Cheryl found employment at Manpower Services. Although she was able to support herself, her employer did not offer health care benefits. She had another flare-up of Crohn's. She waited 6 months before going to the hospital because she had no insurance and she didn't know how she would pay for her medical bills. She was eventually admitted into the hospital, and in August of 1983, Cheryl had an ileostomy. She was able to apply and receive Medicaid to help cover the costs of the treatments.

She then found a job at 7-11, and eventually, Cheryl was offered a salaried position and earned about $12,000 a year.

By October of 1985, Cheryl was again suffering the effects of Crohn's. She waited some time before going to the hospital because 7-11 offered no health insurance benefits. Cheryl was always trying to get some kind of insurance so she wouldn't have to go through an ordeal of finding help each and every time she needed medical care. She called insurance companies like Blue Cross to find out how much it would cost to buy coverage. Because of her poor health history, the monthly payments were just too much for her to afford. She kept trying to apply for medical assistance through the State, but she was always turned down either because she made too much money, she had a job, a car or did not meet the Medicaid program's definition of disabled.

By September of 1986, Cheryl developed peri-rectal abscesses. But again, she didn't seek treatment until the end of 1987 or beginning of 1988 because she was very scared. She had no insurance, and she didn't know how she was going to able to pay for the treatment. Finally, in March of 1988, Cheryl had outpatient surgery for the abscesses. Cheryl set up a payment plan for this bill because she had no insurance and she couldn't get any.

She then started seeing her doctor about every two weeks and began paying for her prescription expenses.

On May 15,1989, Cheryl was forced to resign her position at 7-11 in order to be admitted into the Westland Medical Center. She was losing weight, very run down and in a great deal of pain.

Cheryl applied for the Hill-Burton Funds from Westland Medical but was turned down because her $12,000 a year income was too great to qualify. She also applied for Medicaid but was told that she didn't meet the definition as disabled and was turned down. On June 28th, Cheryl was released from the hospital for the day to be a witness at the Senate Finance Subcommittee hearing for the uninsured to tell her story. On June 29th, Cheryl was granted Medicaid. Within two weeks, she was released from Westland Medical. She was on a home i.v. system, and a nurse came out to her house twice a week to check her.

Unfortunately, Cheryl became very ill in October with a severe infection and was admitted back into the hospital. On October 10, 1989 at the age of 29, Cheryl passed away.

I came here today on behalf of Cheryl to urge everyone involved to please work to find a solution to the problem of the uninsured. The goal of the Senator's plan to provide health care coverage for the uninsured people is a most important one. I know all the stress Cheryl went through in her 13 years of having Crohn's disease without medical insurance.

Because her employers did not offer health benefits, Cheryl was constantly trying to find another source of help. I know many others are feeling that same kind of stress and hopelessness at not knowing how they are going to pay for their medical bills or even if a hospital will admit them for treatment. I believe all businesses, big or small, should at least offer their employees some kind of insurance, evenly with a co-payment or deductible. Cheryl was willing to help pay for coverage. She just couldn't do it alone.

Also, States should lower their qualifications for Medicaid in order to provide assistance to the uninsured who are unable to get coverage through their employer.

I can't help but believe that Cheryl's life would have been different if she would have received immediate medical attention throughout her illness.

I want to thank you, Senator Riegle, and the Committee for giving me the opportunity to speak here today on Cheryl's behalf and on behalf of all the uninsured. We must try to work together to help the uninsured. We're not just thinking of ourselves now, but we must also think of our children's future.

Thank you.

[The prepared Statement of Luann-Nunnally appears in the appendix.]

Senator **Riegle**. Luann, let me just say that is such a powerful Statement that you have given us and such a powerful story. I appreciate how hard it is to talk about it. I know how proud your sister would be. You have your husband Robert with you today. We appreciate his being here.

I want to acknowledge two other people in the audience who are with you and who are part of this story, your other sister, Phyllis Kuzava. Phyllis, would you stand up, please, so we can see you? Also, I would like to ask Rich Martin to stand. Rich was the fiance of Cheryl and was there every minute of the way. Let's give them both a round of applause.

[Applause.]

Senator RIEGLE. Let me say to all of you that Cheryl is very special to us because I think she so powerfully illustrates what we need to do, how we need to change things. She was so wonderfully brave to leave the hospital to come in and testify last year. I remember at that hearing her sitting where you are now in that other room. It is so important that you have come today to tell her story and to emphasize what is happening; how people are being hurt and what needs to be done about it.

The fact that this country and our system really failed her for so long, is a crime. It is a crime against decency, and it is a crime against our people when we don't organize ourselves properly to meet these terrible medical necessities that strike, and they strike people in all circumstances.

For someone to have their life end at age 29 or 19 or 6 or 35 or whatever because they were not able to receive the help along the way cheats this country, it cheats those people, and it cheats their families. America is diminished by that. It is a failure. It is a collective failure when we allow that kind of thing to happen.

It doesn't have to be that way. The one thing we know is that if we have the will to change it and make it different, we can. If we have the will, there certainly is a way. I feel so strongly about Cheryl specifically and about the important testimony that she gave and the example that she represents, that after she passed away I wanted to say some things about her on the Senate floor and did. On the 21st of November of last year, I went to the floor and entered some comments as a tribute to her.

I want to say something about it now, because this is why we are here, situations exactly like this one. This particular tribute to her was to acknowledge Cheryl Eichler who, at that time, was 28. The tremendous pain and suffering that she had endured over 12 years of her life did not embitter or depress her. It caused her to have a great conviction and a great passion to try to do something about changing things so others could be helped. That is why she left the hospital that day to come to our hearing, to give, exceptional testimony. It took great strength and courage for her to do that.

As Luann has said, Cheryl worked. She worked hard, but she could not get health insurance at her place of employment. So many times when she needed health care, she did not go to get it because she did not have the money to pay for it. During her stay in the hospital in June of 1989, she accumulated a bill of over $34,000. She was forced to resign her position. Even then, she was denied Medicaid until finally, that was changed.

Her fiance, Rich, was telling us earlier that when she was taken back into the hospital shortly before her death that it looked like she was going to come through that situation. She seemed to have been getting stronger and her color was good. Then all of a sudden, things turned the wrong way and we lost her.

I think it is important for us to focus on specific people because if we don't think in terms of the specific people, it starts to get fuzzy and loses its meaning. We can get lost in thinking it is somebody else's problem when it is our problem; it is everybody's problem.

If we are going to be the kind of society that we should be, we have to care about each other and help each other through these kinds of difficulties, especially these terrible medical problems that can strike any of us without warning.

So I am going to just come down, and present you a copy of this which I had framed. I want to ask you, Rich, and Phyllis, as well, if you won't come down and stand here a minute. I want to just present this to the four of you. Would you just come down here a minute?

[Whereupon, a presentation was made by Senator Riegle.]

Senator RIEGLE. I think it is fair to say that Cheryl is going to play a very big part in getting the health care package in place that we are talking about. She is going to continue to have a very positive effect on changing things for the better.

We had scheduled next a witness from Warren, Carole Renaud, who has six-year-old twins with Down's syndrome who do not have health insurance, though the rest of the family does. This is one of the terrible anomalies in the health system. Very often, people that need the health care the most are the ones that are told they can't have it. They can't have it because they need it. I mean, that is the ultimate irony and insult of the current system. If you really have a desperately serious and expensive medical problem, then depending upon your circumstances, the health care system really doesn't want you because you are too expensive and you can't pay the bills.

Again, anybody that thinks about it for very long realizes that this is precisely the person that needs the health coverage. The worse the problem, the more they need coverage. Rather than walk away from that person as a society, I think society has to reach out and gather those people in and make sure that they get the coverage and care that they need.

She was not able to come today because of the weather. We will insert her testimony in the record.

[The prepared statement of Carole Renaud appears in the appendix:]

Senator RIEGLE. Our next witnesses have come from a great distance and also have an important personal story to tell. Arlene and David Dilloway have come from Emily City today. They are going to discuss the difficulty that they have had in obtaining health insurance for Arlene, who has diabetes, a very common problem in our society. Almost every family has someone who is suffering from this condition. It is certainly true in my own family.

The Dilloways have been trying to get coverage through the public and private sectors. The private sector health insurance companies told Arlene that she is not eligible for benefits because of her diabetes. They believe Arlene's condition prematurely deteriorated because of her lack of insurance. This is the view that our witnesses have and I tend to share it.

There is very real likelihood that her condition, by not being treated properly at an earlier point in time, has become far more serious. So she has come with her husband today to tell us about that. I thank you very much for doing so. Why don't you pull that microphone over so you can be heard throughout the room and tell us your story.

STATEMENT OF DAVID AND ARLENE DILLOWAY, LAPEER, MI

Mr. **Dilloway**. Thank you, Senator Riegle. My name is David Dilloway. This is my wife Arlene. I appreciate the opportunity to be here again to talk with you. Our experiences with the Medicare and medical systems they almost, while they are not as bad as Cheryl's, they could have been.

I previously testified before this Committee. At that time, I indicated that Arlene was uninsurable. We tried both public and private health insurance programs. However, no one would accept her at that time.

The private insurance companies told us that because she was diabetic, a pre-existing condition, they would not insure her. In fact, most insurance companies would not even take an application, and those that did refused her.

The Social Security Administration told us that she did not qualify for Social Security disability for two reasons: She had not worked sufficient time in the previous ten years, and she had not been totally disabled for 12 months.

In addition, she did not qualify for Medicaid because I was working and making too much money, and we had very meager assets, which was enough to disqualify us. I do believe that Arlene's condition prematurely deteriorated because of being refused needed medical attention due to lack of insurance or money at the University of Michigan in Ann Arbor.

They absolutely refused to admit her because we did not have money. Lapeer Regional Hospital, also, one week later, after, told us they would not treat her because they were inadequate to handle her serious condition. I do not know if this was the real reason they turned her away.

Since I last spoke, Arlene's physical condition worsened to the point that her kidneys failed completely. She is now on dialysis treatment twice a week. Because of this, she now qualifies for a Medicare supplement or insurance through Social Security.

This, as any elderly citizen will tell you, falls woefully short of covering your medical needs. There is approximately, if I added right, $1,000 deductible, plus it only pays 80 percent of medical treatment. The Medicaid that also became available to her as a result of going on the dialysis machine, which qualifies her as disabled, costs us $500 per month for this coverage. I paid $6,000 last year in medical spend-downs, and I am not covered.

Currently, we pay a $30 Medicaid premium; there is a $63 payment to Blue Cross/Blue Shield and her prescription drugs are over $180 a month. As I indicated, the Medicare covers 20 percent of this; the Blue Cross/Blue Shield covers the rest of it, most of the rest of it but not medications.

As I Stated, I have no insurance whatsoever. I work for a small construction company that pays me a salary. It does not provide health insurance. I could receive private insurance if I could afford it, but I just cannot afford it. I am not eligible for public assistance because my income is too high, and I have not been disabled for 12 months. This is why I am not covered.

I ask myself, "what would happen if I got sick?" Well, I did get sick. I had no coverage. I had a $5,000 hospital bill. I have got to pay it. Medicaid would not Pay it because I was not disabled. Our financial situation is basically the same or maybe a little worse than when we was here last time. When I set down on paper and add up the bills, it is more than I make. I don't know how we keep going other than the generosity of some of our friends.

Because of these previous hospital bills, I now have four court judgments against me. This is only about 20 percent of what we owe. Because of these court judgments, I have also had my bank account guaranteed. They tried to guarantee my income tax refund which, unfortunately for them, there is none. I am going to owe about $2,000. I only make so much; I can only pay so much.

But the courts and the lawyers for these hospitals do not take this into account. When they guaranteed my bank account, they took over $700, which was my house payment for that month, as well as her medical expenses. This was in December.

As you have indicated, I feel like I am really falling through if cracks of the present system. If any plan that you approach guarantees us the availability of health insurance at a reasonable cost, comparable to private insurance, then I am all for it. If it is offered on a sliding scale so that people like Arlene who have pre-existing conditions that need health insurance, it must be available and affordable to us. We should not be allowed to be denied medical care.

But really, it irritates me or makes me mad at times when I go to the drugstore and I am sitting there with $180 worth of bills and somebody else will pay 50 cents for the same thing. I sure wish I could have that.

If, when I could have afforded it and I wanted to and did look for insurance, and I said, "No, I don't want to pay the price, " then it is shame on me, but I did, however, and I could not find any. This is why it makes me so depressed and irritated that why can't my wife be covered?

Medicaid, as I said, falls very short of helping those in need. It will never work for us, because I refuse to your income is too high. You have too many assets."

If you get rid of everything, well, maybe then they will help you. But I found out it costs $6,000. The rules and the eligibility requirements for Medicaid are absolutely unrealistic. I have, knowing, having been in there, I know for a family of two such as ourselves, they allow a housing allowance of $180 a month for shelter. What can you rent for $180 a month in this time? These programs need to be brought into more realism with today's economics. As I have Stated all along, I am willing to pay for insurance, but it has to be at a reasonable rate that I can afford.

I currently make about $20,000 a year which, prior to these conditions, I could have afforded insurance, but it was not available. I would like to see insurance available through all employers, either paid by the employer or at the very least, available for the employee to buy himself. But it must be there for us.

The last point I would like to make is most people who have insurance, they say, "well, this couldn't happen to me." Well, I thought so at one time, too, when I had insurance, but when I got laid off, we went on Medicare or Medicaid; when we went back off, insurance was no longer available to us. Think about it, folks. But for the grace of God, you might be sitting here.

Thank you, Senator Riegle.

[The prepared statement of David and Arlene Dilloway appears in the appendix.]

Senator RIEGLE. Let me thank you, as well, you and your wife, for coming over from Emily City to share this with us.

I think both of the stories we have just heard, tell the whole story. I mean, we could have 1,000 witnesses or we could have two; what we have heard here lays out the nature of the problem. I want to say to you and your wife how much I and, I think, others here who heard you today and before appreciate your courage and your strength for hanging in there in the face of almost impossible circumstances. Things that threatened to break your own health, probably had a hand in your own health problems because of the stress and the difficulty of trying to cope with the impossibility of the situation that you are facing with Arlene.

I am struck, as you tell the story so clearly and so powerfully, that in a sense, our country, has unwittingly, not only failed to help you; in certain ways, we have acted in a fashion that make your problems even worse. We have made it even more difficult for you to cope with these problems and to get through them. We can't have a situation where, by accident or design, the country works against its people.

The whole concept of the United States is that the country is the people and the country has to work to help the people. If we have got a situation, whether it is a health problem or something else, the country, should respond and help that person. Otherwise we are all an island unto ourselves and we really aren't a country.

So I think these stories that each of you have told illustrate the fact that major changes need to be made, and responding to the health needs of our fellow citizens is really a wonderful privilege of citizenship in a nation that is supposed to care about its people. I think we have to understand the foundation of not just the problem itself but how our philosophy leads us to understanding why it is necessary and proper for us to change things to meet problems exactly like you have described. That is the whole reason to have a country.

Other countries are doing it. Almost every other industrial country today has a health insurance system that covers all of its people. We are the only one with the exception of South Africa left that doesn't have one. Yet we are spending an extraordinary amount of money on health care, I cited earlier. Not only are we spending a ton of money for health services in this country, but we are not doing it the right way. So many of our people are in desperate circumstances of needing health care but cannot get it or pay for it.

I think everybody in the State of Michigan owes a debt to both of our witnesses here on the citizen panel for coming and telling these stories. While they are your stories, they are everybody's story. You are speaking for tens of thousands of other people who have desperate health problems in their families and cannot be here and testify. So you give voice to them as well as to yourself.

My commitment to you is that this Subcommittee will present, push and enact a plan as a national response to this problem. This is a citizen government. The reason for this official hearing of the Senate Finance Committee is to allow citizens to tell the government what needs to be done. You have done that very powerfully and very clearly. We hear you. I hear you.

We will take the suggestions and the facts you have given us, and we are going to move ahead. So let me thank you for testifying. I want you to stay as long as it is convenient for you to stay. I don't want you to feel like you have to sit at the table if you don't wish to. Feel free to get a cup of coffee and make yourselves comfortable. Now, I want to go to our next panel.

May I just say again, I think the people who have testified today and those who have come with them really deserve a round of applause. [Applause.]

Senator Riegle. Our next panel was to feature Pat Babcock, who, of course, serves as our State Director of Social Services and who co-chairs Governor Blanchard's Task Force on Access to Health Care. That task force has been examining the problem in Michigan and will be making recommendations on how to solve that problem.

Mr. Vern Smith is the Project Director of a program called Healthy Start, which is the Governor's new health initiative for children. Ms. Babock and Mr. Smith started out this morning from Lansing, but the roads were so bad that they got part of the way and then had to turn back. They called and informed us that they could not be here in person. We will make their written testimony part of the record.

States can take initiatives within the scope of the national problem that we are describing here. Michigan is a progressive leader in trying to find innovative ways to broaden out health care coverage. This new initiative, the Healthy Start program, is aimed at children. Governor Blanchard has recently announced it as one item in that effect to try to meet part of this problem.

We will be inserting their material into the record at this point, and we will note the fact that they had a presentation that they had intended to make to us.

[The prepared statement of Pat Babcock and Vern Smith appear in the appendix.]

Senator Riegle. Let me now move to our next panel, which is composed of executives from city government and from health care institutions. Their testimony will reflect their views on the challenge of providing health care to persons with inadequate health coverage.

We have next, then, Mr. Eli Robinson of Southfield, who is President of the Southfield City Council. He is accompanied by Maria Ward and Jerry Kuhn. The City of Southfield recently organized a task force aimed at designing a plan to resolve the crises that is currently being faced by northwest Detroit hospitals.

Mr. Robinson is going to discuss the concerns of municipal officials about the availability of adequate and appropriate health care services. The Mt. Carmel Hospital, the New Grace, the Detroit Medical Center and Henry Ford Hospital and Sinai Hospital are all experiencing large numbers of patients who need medical treatment but do not have the ability to pay for these services.

The City of Southfield wants to take action before any of these hospitals are forced to close their emergency rooms or, far worse, even the possibility of having to close the entire hospital.

So with that lead-in remark, Mr. Robinson, we are very pleased to have you, and we would like to hear from you now.

STATEMENT OF ELI E. ROBINSON, PRESIDENT, SOUTHFIELD CITY COUNCIL, SOUTHFIELD, MI

Mr. Robinson. Thank you, Senator. Have we got this microphone working?

Senator Riegle. Pull it just a little bit closer. Then they can hear you in the back of the room.

Mr. Robinson. Fine. I am Eli Robinson. I am President of the Southfield Michigan City Council. What I would like to speak about this morning is the concerns that we as municipal officials have about health care and the hospitals, in particular.

First, let me tell you something about our city. We have a resident population of 82,000, which increases to 260,000 during the daytime. One-fourth of our residents are senior citizens. We have 22 million square feet of off ice space, which makes us, I have been told, the third largest office center in the Midwest. Our city covers 26 square miles, is intersected by two major expressways and shares a common border with Detroit, which is our neighbor to the south.

Every time I go to another meeting or a seminar or a hearing, I wind up asking myself the same questions at the beginning and the end of the session: Why are we here? What will we have accomplished and what have we accomplished other than to take time and space?

Those of us from the municipal government side are probably closest to the needs and the quality of life of our residents. For too many years, we have taken too much for granted. We assumed that the only barrier to obtaining adequate health care was an economic one at the level of the individual: If you could afford it, it would be there. Certainly, the technology was there.

The reality of the situation is now that due to financial instability many of the hospitals in our area simply may not be there to provide services, regardless of the economic ability of the individual.

We have seen numerous State and Federal commissions appointed to study the problem, and study they do but produce nothing. We feel that time is of the essence and that there is sufficient blame to go around. The institutions have been guilty of some poor business practices while their finances have been strained by high operating costs and low revenues. Medicare/Medicaid simply do not provide the necessary cushions to cover the unreimbursed and unpaid care provided to the indigent.

Insurance carriers and governmental payers have been guilty of delayed and underpayment practices. State and county budgets are already badly strained. Individuals have been guilty of use and abuse of the hospital facilities, especially emergency rooms, as opposed to the utilization of other first-line, lower-level care providers. There is also current pending State and Federal legislation that would strain the resources of the hospitals even further.

This isn't a political, a racial or a geographic problem. This is a problem for all of us. We in the suburbs are not apart from the problem of the inner-city hospitals. If any of the hospitals fail, what will happen to the others? Will the remainder be overwhelmed by the economics of the situation? Is there going to be a financial domino effect?

Every day and in every part of this country, we read about the horror stories of emergency rooms being temporarily closed to ambulances en route and critical patients dying because of the delay. In Southfield, our excellent emergency medical service has an average response time of 3.6 minutes. But to where will the patient be taken if the emergency rooms have closed or the trauma centers are out of existence?

We who are responsible for the quality of life and the health and welfare of our residents cannot simply sit by and criticize or pontificate. And we are not interested in recrimination or retaliation. We certainly have a moral and ethical responsibility to act to prevent this crisis from going any further.

We cannot accept those threatened hospital closings. It is not just peculiar to Southfield, to the metropolitan Detroit area or to the State of Michigan. It is a national problem. Hospital and trauma care is as critical a part of the environment as infrastructure, as roads, air and water quality, solid waste removal, drug control and other issues that have seized the headlines.

And the answer is not just another Federal mandate for all employers to provide health insurance. It is sheer hypocrisy to mandate, take credit for the good deed and then pass the bill on to business, who, in turn, pass it on to the consumers. been that approach does not provide coverage for certain obvious groups.

The urgent need is for immediate massive financial assistance to stop further erosion of the situation and then the adoption of a stiffly-enforced, non-partisan, if that is at all possible, uniform national policy to maintain institutional quality and availability, including trauma centers and the supporting network of primary health care units.

Funding alone is not sufficient. We need efficient use of those funds. We need recognition of the institutions as part of basic infrastructure of any viable community. We need to maintain the available of emergency rooms for true emergencies. We need a diversion of non-critical care, perhaps a major educational program to identify the appropriate levels of response to specific needs.

We in the cities understand budgetary constraints. perhaps there has to be, if such a thing is possible, a non-partisan triage on spending for infrastructure, and these institutions are part of our infrastructure.

The urgent need is not for another study by a blue ribbon commission of learned experts. This is not merely a matter of wanting another play field or a cultural arts center. For our residents this is more: It is the issue of the viability of our cities as a place to live and work if there is no adequate hospital care. This is literally a matter of life and death, and the time for debate is over.

In the book of Deuteronomy, chapter 30, verse 19, is recorded the following: "I have set before you life and death, blessing and cursing: therefore, choose life that both thou and thy seed may live."

We chose life.

[The prepared statement of Eli E. Robinson appears in the appendix.]

Senator RIEGLE. Thank you very much. That is a very important and powerful Statement that you have given us. Do either of your colleagues want to add anything to what you have said?

Ms. WARD. No, thank you.

Senator RIEGLE. Tonight, this evening, in fact, I am going to be spending some time in the Trauma Center at Mount Carmel hospital to see with my own eyes what is happening. We have been told that the in-flow of emergency traffic is such that it really is overwhelming our hospitals; certainly, in a financial sense. So we are going to be there tonight to see what is taking place, talk with the people and take our own reading on that.

Mr. Robinson, is it your testimony that uncompensated care, that people who come in and need help but who have no insurance but nevertheless, have to be given emergency treatment. Do you see that as a major part of the problem, now, the problem of uncompensated care for the hospitals and the emergency rooms within Southfield?

Mr. ROBINSON. Yes. Our major hospital in Southfield is Providence Hospital. If and when the inner city hospitals are unable to continue to handle their load, if they are overwhelmed, there will be a further flood of unreimbursed care to Providence Hospital, which, as a hospital of a religious order, by their vows, will not turn away anyone. They simply cannot handle the flood; they cannot handle the overflow. They will be overwhelmed.

How can we continue to represent that our cities are viable? The State of Michigan now has a campaign that says, "Say yes to Michigan," but say yes to communities that lack basic health care and the institutions? We have express ways; we have 260,000 people in our cities during the daytime that many of them are commuters above and beyond the 82,000 that live there.

The possibility of emergency incidents on the expressways, with our one-quarter senior-citizen population, the incidents of coronaries and strokes are such that we need those hospitals to be there and to be available for the critical care for the emergency incident. We need them not to be overwhelmed by the lower level tier that perhaps can be taken care of, perhaps by the funding of a national network of walk-in, 24-hour care centers that might be available to provide that lower level.

We need a triage to discern and discriminate between the levels of care that have to be provided. The availability of those emergency rooms must be kept open. We cannot live without them.

Senator RIEGLE. Is it your sense that Providence is running up a mounting operational deficit?

Mr. ROBINSON. I understand the people from Providence Hospital are here and will give you a prepared Statement on that subject, sir.

Senator RIEGLE. All right. What we are finding in most hospitals in the State, all over, not just the urban areas, this is a terribly serious problem in the smaller towns, northern Michigan and western Michigan, as well. We are finding that the problem of people who come in and who are uninsured but who need help and where the bills can't be paid, it is just imposing a crippling debt on most of these hospitals. And the debt just keeps growing.

This is an unprecedented situation. What happens, of course, is if you are open each day and you are handling your normal medical workload, that is what you are there to do, and if the fall-out of that is suddenly a larger and larger cumulative deficit where the bills are being incurred but can't be paid, it is a moot kind of problem. It is a problem that hospitals aren't equipped to deal with because it is, in a sense, outside the scope of what, in the past, they have had to think about.

So the problem of the uninsured, the uncompensated care, is beginning to threaten the very existence of hospitals all across the State of Michigan. I just had the hospital administrators of Michigan come to visit me in Washington, and this was their testimony to me. That is, small towns, large towns, northern Michigan, south eastern Michigan, all across the State, that is the pattern that is developing, in large measure because of the uncompensated care because of people who have serious health problems and no health insurance.

So we are now seeing a secondary effect where many of our hospitals themselves are threatened. The emergency services are threatened, and as you say, if the emergency service is shut down, they have got to go somewhere. If somebody is in an accident on the expressway, and there will be a lot of them today, and they get loaded into an ambulance, they have got to go somewhere to have care. They have got to survive.

Mr. ROBINSON. We cannot afford to have those ambulances diverted in critical care incidents. I have just been informed that Dr. Solomon Hochbaum, who is, I believe, the Director of Emergency Medicine or in the Emergency Medicine at Sinai Hospital is here and is prepared, I think, to speak to some of these issues.

One of the other items is that from our January 11th hospital task force meeting, one of the issues that came up and was spoken to was the fact that six hospitals had over $200 million in indigent care costs for the year 1989. The private sector philanthropic giving can take care of just so much of it. The rest becomes a national crisis. Again, if I may emphasize one thing: Time is running out.

Senator RIEGLE. I agree with you strongly on that. That is why we are here and putting the focus and the attention and the urgency on this issue. I share that feeling exactly with you. We are approaching it on a non-partisan, bipartisan basis, and that is the way it has to be. I mean, it shouldn't even be thought about in any other context.

The task force in the Senate that we have put together is not only between two committees that share jurisdiction, but it is the leading members of both parties. We are working in an integrated fashion. So I think that is a necessary and constructive element which you have recommended to us.

We have next a Vice President for Governmental Affairs for the Detroit Medical Center who is going to be testifying. But you have indicated that someone is present in the audience, did you say from Mount Sinai Hospital ?

Mr. ROBINSON. From Sinai Hospital of Detroit, Dr. Hochbaum.

Senator RIEGLE. We will move ahead in just a minute, but as long as you have made a reference to him, let me just invite you at this particular point in the discussion, if you would like to add a comment relative to the discussion that we have just been having, you might just want to step up and pull the mike over and do that, simply so that we can have the benefit of your observations relating to what Mr. Robinson has said to us. Do you want to identify yourself for the record, and then make whatever comments you wish.

STATEMENT OF DR. SOLOMON HOCHBAUM, CHAIRMAN, DEPARTMENT OF EMERGENCY MEDICINE, SINAI HOSPITAL, DETROIT, MI

Dr. HOCHBAUM. Thank you, Senator Riegle. My name is Solomon Hochbaum. I am the Chairman of the Department of Emergency Medicine at Sinai Hospital in Detroit.

I have been very moved by the testimony that has been presented so far. I am in the position, either fortunately or otherwise, of basically seeing these occurrences on a daily basis in my practice. In the Emergency Department, we are the only group of doctors in the country which the Federal Government has mandated to see all patients through the code of legislation. So we get to see all patients regardless of their insurance, and frankly, we are the safety net, if you will, of these patients who do not have insurance.

Expansion of the Medicaid program for people below the Federal poverty level and the creation of a new public program for those at or above the poverty level but without private health insurance coverage would be helpful.

With respect to these, two items are significant and really should be taken into account. Coverage of both programs should provide for 100 percent of the cost of that service, and it needs to be recognized that especially in urban areas, these two population groups seek a significant amount of their health care from hospitals, primarily through the emergency departments.

The reason for that phenomenon is twofold: First of all, too many private practice physicians have left the urban areas, and those that are left are becoming more selective in their clientele and unfortunately, and speaking for my profession, tend to perform what we euphemistically refer to as "wallet biopsies" prior to seeing the patients.

Senator RIEGLE. Wallet biopsies?

Dr. HOCHBAUM. Right. That is to check the wallet and make sure that they can pay for the services.

Senator **Riegle**. If the wallet is fat enough to be able to pay the bill; is that it?

Dr. **Hochbaum**. That is correct. Emergency Departments do not do wallet biopsies. We are not in the business of checking people's wallets before we check them for their own personal health needs.

Of course, we don't turn people away. Unfortunately, as hospitals are beginning to have more and more financial constraints placed upon them, we are in the position of not being able to provide the service that is being asked of us.

We are a mere four blocks away from Mount Carmel Hospital, which you will be visiting later on this evening. We are pleased that Mount Carmel has developed a trauma center over the years, and we are very concerned about some of the problems that have been coming up over the last year or two. The problems are not specific to our area, necessarily. They are really nationwide, and the problem of availability of emergency care is particularly acute in our area right now. Mount Carmel Hospital, as the trauma center and an institution which has been particularly feeling the brunt of the financial constraints over the last several years, has, in fact, cut back on services that it has been providing.

However, the number of patients seeking those services have not diminished. And we, at Sinai, tend to get the overflow when patients are either too sick to wait for services that are not available any longer at Carmel or are simply brought to us because Mount Carmel Emergency Department is so overwhelmed that the EMS system has to find someplace to which to bring them.

In addition, Providence Hospital, which is in Southfield, only a few miles away, has also been overwhelmed in the same way. Neither Sinai nor Providence have established a major emergency center. That has not been the goal of our institution, and we have, in our own institution, developed programs that are very different from those that Mount Carmel has developed over the years.

If needed, we could not even reproduce those systems over the next several years. That is how hard it is to have a major trauma center available. We are very concerned that that one trauma center in northwest Detroit which, frankly, services not just southwest Detroit, but south of Oakland County, as well, will no longer provide service because of the financial problems that that hospital is facing.

The Sinai Hospital experience is only one of several examples of a frustrated urban hospital in the City of Detroit.

Senator **Riegle**. Isn't it worth noting, as well, that any individual person might be in some particular place at some moment on an expressway or what-have-you have an accident and be in critical condition and taken into an ambulance to be delivered literally to your door? It may be a matter of minutes or seconds as to whether they could be saved or their life is lost or the children's lives are lost or what-have-you, both based on the availability of the service and having competent people there who are not overwhelmed and who are sufficient in number to handle this.

This isn't just a problem of somebody that happens to live within a few blocks of a hospital. This is really the problem of anybody in our State who might, at a particular moment, be in an area that has something happen to them. It doesn't have to be an accident; it can be a seizure or what-have-you, and they can show up on your doorstep even if they come from Grand Rapids; isn't that right?

Dr. **Hochbaum**. That is correct. We are, in addition, in the major problem of hospital rerouting of emergency medical services. Today, I would venture to say that probably 50 percent or more of the emergency departments in the southeast Michigan area are not able to receive emergency medical patients via EMS.

Over the last several months, this problem has become greater and greater and is directly tied to the availability of hospitals to staff their critical care and monitored units with nursing staff, with the availability of hospitals to provide the level of service that is necessary so that their emergency departments can remain open and available to incoming patients.

Senator **Riegle**. Do you think the public understands this right now?

Dr. **Hochbaum**. No.

Senator **Riegle**. I mean, as people are driving up and down in the snow today, do you think they have any idea that they could have an accident and find themselves in a situation where they have an urgent need for emergency care and they may not be able to get it?

Dr. **Hochbaum**. No, I don't believe that the public does understand that. I am the immediate Past President of the Michigan Chapter of the American College of Emergency Physicians. We in the College have a national task force that is addressing this issue right now. We feel it is a major crisis in health care as do the providers of EMS services throughout the country.

I am also chairing a task force for the Detroit Wayne County EMS Council on Hospital Rerouting. This has become a very, very serious problem in our area, in southeast Michigan, in particular. It is fairly typical of similar problems throughout the country, something that has been referred to as EMS gridlock, where hospital emergency departments simply do not have the capacity to accept any additional patients from those who are already there and provide appropriate and adequate levels of medical care.

Senator **Riegle**. Have lives been lost as a result of this?

Dr. **Hochbaum**. We don't have exact data to answer that question. My sense is that the medical care that the citizens of this country have come to expect as a right rather than a privilege is not meeting their expectations a good deal of the time. As you point out very appropriately, it doesn't really matter where you live or even how much money you have.

Senator **Riegle**. That is right.

Dr. **Hochbaum**. Because if you happen to be driving by and have a medical problem and wherever you happen to be, I can tell you that according to the statistics which we manage, you have just as great a possibility of finding a hospital emergency department not available to you driving through Oakland County as you have driving through Wayne County or the City of Detroit.

No matter what your wallet shows or who you are, you may not have the ability to gain access to those emergency medical centers.

Senator **Riegle**. Let me just make one more point and then I will let you finish and hear from the others. I would infer from that that logic says we probably are losing some people; there are some people who are in emergency circumstances, and have either been badly injured in a car accident or some other situation, and if they don't get quick help of the kind that they need, they are not going to pull through. So I think it is just logical to assume that we are losing some number of people and that the risk is there at any given moment.

How complete is our data on people who either get rerouted or are not able to get the kind of emergency care that they need? I mean, how coherent is the data or are the statistics there if somebody wanted to pursue that?

Dr. HOCHBAUM. We are in the process of gathering that data right now. That is the purpose of the task force which I chair. I can give you experiences from my own hospital where we know exactly what the problems are in maintaining the availability of our emergency department.

I can tell you, based on the information that I have, there is a domino effect that clearly occurs.

Senator RIEGLE. So to take it one more step, right here in this immediate area, for example, if any of the press people in the room wanted to pursue this in order to gather and provide the public information to people as to what is happening here in the build-up of this crisis problem, they could come to you and you could help provide information so that at least this problem can be laid out there for people to understand? So that they can understand they are at risk?

Dr. HOCHBAUM. Certainly. The domino effect is very important, because, as Mr. Robinson pointed out earlier, it used to be thought that living in a suburb you were safe. The urban sprawl of lack of resources would basically not touch you if you were in the suburbs. But that is not the case.

Clearly, as the problems reach certain hospitals and they become unavailable for providing care, people will try to get care wherever they can. There are no longer private practitioners in sufficient numbers to care for the population of the inner cities. In particular, Detroit has that problem, and so patients will go to wherever they can get care, which is going to be hospitals and, in particular, hospital emergency departments.

As those hospitals become overwhelmed and, secondarily to that, the emergency departments become overwhelmed, they will topple and fall and will reach out into the suburbs, and those hospitals will become overwhelmed and so no matter where you are, you are going to feel the impact, of this, in particular, as the acuity of your medical needs reach you.

There is no one in this room that doesn't have a problem. When you asked earlier whether lives have been lost, I can't really give you a specific answer to that. In medical terminology, we use the terms mortality and morbidity. Mortality refers to if death of an individual; morbidity refers to some compromise of that individual's health.

There is no doubt in my mind that morbidity has been significantly impacted by this, as evidenced by the first two witnesses that presented testimony today. It is very clear to me that if they had availability of primary health care, they would not only not need emergency care most of the time but would probably be healthier as a result of that.

Both of the conditions described are imminently treatable with appropriate medical care. What is happening in our emergency departments is that we end up seeing these patients after they have neglected their illnesses because they haven't been able to obtain adequate primary medical care. This is a major problem.

Senator RIEGLE. Let me ask you just one other question in that respect. If you take the financial pressure on hospitals now that comes in the form of uncompensated care in terms of people who come in without health insurance, if you take that component and try to think of how many percentage points of 100 percent of this terrible cost situation and financial situation facing hospitals, how much of it comes from that kind of uncompensated care? Then can you also place a value judgment as to the additional part that relates to people who come when they are much sicker because they didn't have the health insurance to go earlier when their problem was less difficult or treatable? The fact that they show up at a far more advanced stage of difficulty and therefore, need the emergency care which is more expensive and more difficult for them and involves more pain, more everything. If you take those two components of people who lack health insurance, how much of the total problem do you think that constitutes today in terms of this emergency situation building up in our hospitals?

Dr. HOCHBAUM. Well, to be specific, the uncompensated care in our institution is approximately 11 to 12 percent of the total number of patients whom we see in the emergency department. At Mount Carmel, which has generally been the hospital of choice because of the size of the emergency services that they have, winds down its ability to see patients, that percentage is growing in our institution.

Furthermore, as you point out, the more acutely ill a patient is, the more need that that patient will have for more expensive health care. Frankly, we see that occurring, as well.

The acuity level of the patients who have been presenting to our emergency department has certainly grown significantly over the last several years.

Senator RIEGLE. But in terms of this build-up of financial crisis in hospital after hospital, it sounds to me as if at least half of that financial crisis would be coming from one of these two sources. Is that a reasonable judgment to reach or is there some other mysterious out-of-control cost element that is piling in here that is beginning to bankrupt our hospitals?

Dr. HOCHBAUM. Well, I am a doctor, and although I have been involved with many of the issues, the larger issues over the years, I am not an expert on hospital financial issues. We are blessed with several of those here today that can probably answer that question far better than I.

Senator RIEGLE. I will pose that question to them. I am going to have you finish so I can get to them. Why don't you go ahead and conclude with your comments here?

Dr. HOCHBAUM. In our hospital, we see over 30,000 emergency patients every year, and that number is growing. We started out, when I first got to Sinai 5 years ago, seeing less than 20.000, and that is a very significant increase over 5 years.

These patients account for about one-third of the total admissions that enter Sinai Hospital. 58.9 percent of those in patient admissions live in the City of Detroit; 22.9 percent live in Oakland County; 9.4 percent live in Wayne County and 8.8 percent originate from other geographic locations.

Of those patient admissions, Sinai Hospital operations loses millions of dollars a year in uncompensated, and, in particular, under compensated care.

The estimate that we have at Sinai Hospital is that Medicaid payments pay for approximately 75 to 85 percent of our costs in treating those patients. Therefore, every time a Medicaid patient is admitted to the hospital, the hospital loses money on that patient.

Hospital emergency departments are becoming flooded with patients who walk in or are brought into the facility by car in addition to those who come by EMS. They have to be seen, and frankly, for defensive reasons, since Wayne County is one of the most litigious counties in the country for malpractice and negligence, all too often, excessive service is provided; tests which we would not normally do are done so that we can prepare ourselves to defend a malpractice or negligence suit.

More and more, the EMS service is rerouted to another hospital, and consequently, trauma cases, which are on the increase in most urban areas, are overwhelming the system right now. As I pointed out, underfunding by Medicare and Medicaid will cause the closure of hospital trauma services, we have known for the past several years, and will not support the urban area's EMS transportation system, and that is already happening.

In 1990, urban hospitals will just not have the financial reserves that resulted from historical cost shifting to make up such losses. Certainly, Sinai Hospital does not now. Nor can Sinai Hospital provide the level of charitable care that it has in the past simply because our greatest source of funding, mainly the insurance industry, does not fund, does not cover the costs that the hospitals have in providing service.

We do not disagree that the health care system is in need of reorganization. In fact, such work needs to be speeded up. Until that effort is accomplished and no matter what the outcome is, the current health care system cannot survive continued Medicare and Medicaid underfunding in the name of cost containment, let alone absorb the costs that are resulting from the uninsured and uncompensated care.

Cost containments cannot continue as a Federal and State effort characterized by, "Just deciding to pay less." That policy will likely result in the government's "Guaranteed Hospital Bankruptcy Act of 1990."

We at Sinai are particularly concerned with our ability to continue to provide emergency care to all patients in the Detroit and south Oakland County and western Wayne County area, which is our traditional area of patient care. We would like the help of the government and applaud your efforts to look into this issue and come up with a solution rapidly enough so that we can help hospitals which are currently facing decline in their economic status and possibly closing of their doors.

Thank you for the opportunity.

[The prepared statement of Dr. Solomon Hochbaum appears in the appendix.]

Senator RIEGLE. I appreciate your testimony, and it is helpful to us. I want to go, in just a moment, to our other hospital representatives who are here. We have got two other scheduled witnesses that we need to hear from this morning.

I just will say in passing that, as you know, the budget has just been sent down from the Administration and proposes additional, very substantial cuts in Medicare. I think that feeds directly into the problem that you are describing.

Of course, if you will look at the pattern over the last several years, there have been a lot of mandated cost reductions in that area, but there is some question as to how that is to be accomplished. It is one thing; you can't just wave a wand and ask costs to disappear when people are coming through the door and requiring very expensive health services. So your point is well taken, and I appreciate your Statement very much.

Let me now go to our next panel here. It leads in very naturally to what we are discussing. Mr. Robert Yellan of Detroit is the Vice President for Governmental Affairs for the Detroit Medical Center, and also, David Benfer of Detroit, who is the Executive Vice President of Henry Ford Hospital. He chairs a task force at Henry Ford Hospital that is organized to evaluate and create new financing of delivery systems for indigent care in southeastern Michigan.

I might say, as well, that the Detroit Medical Center includes seven hospitals, six of which are in the Detroit area: Children's Hospital; Detroit Receiving; Harper Grace Hospital; Hudsell; Heron Valley and the Rehabilitation Institute.

I know their estimates are that the Medical Center will lose approximately $68 million in uncompensated care this year alone. I know you will speak about that, but at this point, Mr. Yellan, let me call on you.

STATEMENT OF ROBERT J. YELLAN, VICE PRESIDENT, GOVERNMENTAL AND REGULATORY AFFAIRS, THE DETROIT MEDICAL CENTER, DETROIT, MI

Mr. YELLAN. Thank you, Senator Riegle. My name is Robert Yellan, and I am the Vice President for Governmental and Regulatory Affairs for the Detroit Medical Center.

You have mentioned our seven hospitals, all of which form the basis for the academic teaching programs at Wayne State University, the Medical School, Nursing School and other health professional education programs.

I am pleased to provide comments to the Senate Finance Subcommittee on Health for Families and the Uninsured, and I am most pleased that one of our own Senators is chairing that Subcommittee, which gives those of us in Michigan direct ability to speak to some of these issues which are affecting us.

We have been asked today to give our views as the largest provider of health care for the uninsured in Michigan on an outline of options prepared by your Subcommittee, which are designed to provide health care for all Americans.

I believe that the title itself is an important Statement. A document called "Education for All Americans" or "Highways for All Americans" or even "Retirement Benefits for All Americans" would not signal the need for any major change in our public policy in this country. "Health Care for all Americans", however, does signal such a change, because today, we have no policy to provide health care for all Americans.

Our current system, which is unique, as you pointed out, Senator, among all the nations of the world, is really made up of a collection of public and private programs to provide health care coverage. While there may be inefficiencies in this particular model of health care coverage, it reflects our basic American tendencies towards pluralism, and I believe that most Americans are comfortable with that pluralistic system.

A pluralistic system can accomplish the goal of Providing access to care for all Americans, but only if there is an adequate program within which everybody fits. The problem that we are facing is, as has been pointed out by previous witnesses, that our pluralistic system has resulted in major gaps in assuring health care for all Americans.

An estimated 37 million Americans, one million of whom live in the State of Michigan, currently have no source of health care coverage, and many, many millions more have coverage that is inadequate to meet their basic health care needs.

We have all allowed ourselves to close our eyes to this situation for a very long time in this country by a variety of complex cross-subsidies through which health care providers, especially hospitals, have been the de facto insurer of last resort for this population, those who are not fortunate enough to have a job which provides adequate health care benefits or who are not considered the "deserving members" of our society.

Senator RIEGLE. I just want to underscore the point you have just made, because I have not heard it put that way. I think it is very important to underscore, that, as you have just said, hospitals have become the health insurers of last resort, not by design, in a sense, by accident. That is a very important fact that starts to explain this growing crisis that we have out there now.

Please continue.

Mr. YELLAN. While there may be some communities in this nation that may get by with this system for a few more years, in the Detroit area and in many of our major metropolitan areas of the country, this de facto system is rapidly falling into a crisis situation.

Our medical center happens to be right in the middle of that crisis in metropolitan Detroit. The DMC is projecting that in this year, 1990, we will provide over $65 million worth of uncompensated care to the uninsured care, care to those who have no public coverage or private coverage of any sort, and who have no resources to pay for their care. That does not include the uncompensated care provided by our physicians which we believe to be tens of millions of dollars more.

That uncompensated care for our hospitals now accounts for approximately 6.5 percent of all care delivered in our hospitals and represents a 38 percent increase in the past 2 years.

The provision of uncompensated care is a major contributor, along with underpayment from existing public programs, to three consecutive years in the DMC of significant and growing operating losses which have now reached $35 million annually. The fact is that neither we nor the other major hospitals in metropolitan Detroit are in a position to continue to be that insurer of last resort and remain financially viable to serve our communities. It doesn't take too many years of $35 million losses to run down reserves and run out of cash, Senator.

So what insights can we provide being the largest provider of that care in our communities to bear on the preliminary options that you and your Subcommittee have laid out ?

First of all, the vast majority of our uncompensated care results from non-pregnant adult patients between the age of 21 and 64 who are not permanently disabled, as defined by the government, and who have limited financial resources.

That is the result of two factors: First of all, as you pointed out in your opening comments, Michigan has been a leader in providing access for pregnant women and young children, and the United States Congress has assisted in mandating that policy over the past several years through incremental improvements in the Medicaid program and others.

Virtually all pregnant women and young children in households with incomes less than 200 percent of the poverty level in our State can have access to care. So that has helped.

But the other side of that is that the Medicaid program's reliance on categorical eligibility requirements have left major gaps in coverage for even the poorest in our nation.

Thus, we believe that the highest priority for any solution to the problem of the uninsured is the establishment of a new public program or a restructuring of Medicaid, which provides payer of last resort coverage based solely on income without regard to categorical restrictions or relationship to the public assistance coverage for those below 100 percent of the poverty level, with a phase-in to higher income levels with consideration of cost-sharing provisions on an ability to pay basis.

The second lesson we have learned to our experience is that approximately 50 percent of our $65 million in uncompensated care is provided on an outpatient basis, either in the emergency departments of our hospitals—and we provide 200,000 emergency visits a year—or in our outpatient clinics. Much of this care is of a routine nature and treatable in virtually any primary care physician's off ice. The problem is that these people have no source of primary care because of a shortage of primary care physicians in the inner-city and because those physicians who do serve the inner-city are unwilling and unable to provide care to this population.

The fact is because of low payment rates and paperwork and the enormous burden of liability insurance in our community, most private physicians are not even accepting new Medicaid patients, let alone those patients who have no source of payment. Thus, we believe that any program to address the uninsured must provide coverage for a broad range of physician, diagnostic and treatment services and must assure payment levels that enable the covered population to receive that care in the least costly setting.

The third lesson we have learned from our experience is the recognition of the role of substance abuse, violence and other reflections of our society's ills as major contributing factors in the growth of and the cost of uncompensated care. About half of our uncompensated care is provided through the Detroit Receiving Hospital and University Health Center, which is one of the few hospitals in the nation dedicated to the provision of emergency and trauma care exclusively, and through its doors come the victims of gunshot wounds and stabbings, motor vehicle accidents resulting from alcohol abuse, the medical consequences of illegal drug use, rape and those suffering from the effects of poverty, poor nutrition and homelessness.

Any comprehensive approach to the uninsured must also recognize that a simultaneous effort must be made to reduce these underlying causes of illness and disease.

We have also learned some lessons through the Medicaid program. While State administration has enabled the tailoring of Medicaid to the political and health care environments of each State, we believe that there is little question that the States have had too much flexibility with respect to coverage, benefits and payment systems.

In our view, coverage under any new public program must have uniform coverage requirements for all States, consistent minimum benefit packages and provisions which prohibit what we have recently experienced in Michigan with regard to payment policies. To be more specific, incremental improvements and expansion in coverage have been allowed to be financed by decreasing the payments to health care providers.

It does us no good to receive payments for those who are currently uninsured and have that much or more reduced in payments for those who are currently insured.

Lastly, I want to get off the subject of the public responsibility in this program and turn to the private sector responsibilities, because a comprehensive solution, as you pointed out, cannot rest solely on a public program solution. Clearly, many of the patients we serve who contribute to our uncompensated care burdens are employed at least on a part-time basis or an intermittent basis or in low paying jobs without health insurance as a benefit of that employment. We believe that the time has come to consider mandating a basic level of health " insurance for all who are employed and their dependents by requiring employers to either purchase coverage directly or to pay into a public fund to provide coverage.

We also believe that this requirement must be imposed at the Federal level in order to avoid competitive business climate impact among the States.

This is not a revolutionary concept, as some might suggest. Our nation has, for many years, mandated retirement benefits, workers compensation benefits and unemployment insurance benefits through employers. The problems created by employees without health care coverage will continue to grow as our economy, particularly in Michigan, grows from and shifts from a manufacturing base to a service sector base.

But it is clear we can't approach mandatory coverage in a cavalier manner which ignores the burdens that such a policy would impose on small businesses. We support the use of the tax code and other financial mechanisms to relieve the burdens on small business in order to assure that health care benefits for those in the work force and their dependents can be provided. We also recognize that any comprehensive approach to the uninsured must be coupled with reasonable measures to help control the overall increase in health care costs.

The option paper that the Subcommittee has prepared identifies a number of approaches which we believe are supportable and necessary, including promotion of managed care, evaluation of cost effectiveness and medical treatment, incentives for the rational elimination of excess system capacity and medical liability insurance reform. Others will undoubtedly be needed in addition to those in the option paper.

On behalf of the Medical Center, we appreciate the opportunity to share our views with the Subcommittee and look forward to continuing to work with Senator Riegle and the other members toward some solution.

[The prepared Statement of Robert J. Yellan appears in the appendix.]

Senator RIEGLE. Thank you very much. That is an excellent Statement, and I appreciate the fact that you have geared a number of your comments to ideas that we are considering in our options paper. That is very helpful to us.

I am struck, as we go along here in introducing David Benfer, that as we come across, the picture is filling itself in, if you will. If we look at all the dimensions of this, from the individuals who are affected through our public institutions that have to try to respond as best they can, and into our health care system—and we will end up with our private companies here shortly—the interrelationship and nature of how this problem that we haven't done a very good job of handling, is manifesting itself with damaging effects in a number of different places.

One might ask if you would come the other way around and say, well, what are the big virtues or advantages of the current system that we are getting? That would begin to justify this pile-up of difficulty that we are seeing: people who don't have insurance; people that get there late; who die too young; hospitals that are being crushed under costs that they can't handle; a whole host of related problems.

We are going to hear, as well, in terms of how it is affecting even our economic international competitive position. I think it is obvious that no matter which way you look at this problem, it is time to change. It is time for a fundamental overhaul of what we do, and in so doing, we can solve a lot of problems at once, because the damages and the side effects are now going off in so many different directions that that helps build the clear need for a fundamental change. But the fundamental change, if we are wise enough to work our way through it, can now help us solve a lot of problems at once.

So in a sense, a well-crafted universal health coverage system can let us now solve many problems simultaneously that need solution.

I will just say one other thing, as well, and that is you make a reference to the importance of this particular Subcommittee and the Senate Finance Committee now being in the hands of Michigan, if you will, and the Michigan chairman. These committee chairmanships and subcommittee chairmanships are a matter of seniority, and is a matter of, very often, chance. And so while we have this particular Subcommittee now within the reach of the thought and opinion within our State in a very direct way, that may not come again in anybody's lifetime.

That is just sort of the way that things manifest themselves in the way of an opportunity. I think what it does is it not only gives us the opportunity, but obviously, the responsibility, as well, and the chance to play a particular role as a State in crafting a national answer. That is why the time we take with these hearings and the time that all of you are taking with the preparation of your testimony in coming and telling the facts that we need to have in putting together the base of competent integrated information, gives us the foundation to actually go ahead and prepare a national answer, and to craft this new system.

So this hearing, to the extent that all of you are participating in it, we are doing the country's work here today. It is giving us a chance as a State to, I think, exercise some leadership collectively in terms of bringing our knowledge to bear, bringing our ideas to bear and working them through until we have something we can offer the country as an alternative.

I think Michigan will find itself—and we are now in a position—to play its largest part in crafting this new universal health care system as any State in the country. So I say that because each word said by each witness becomes one of the building blocks that we will be using in terms of getting this package developed.

With that, Mr. Benfer, we are pleased to have you here representing Henry Ford Hospital, and we will hear from you now.

STATEMENT OF DAVID W. BENFER, EXECUTIVE VICE PRESIDENT HENRY FORD HOSPITAL AND GROUP VICE PRESIDENT, HENRY FORD HEALTH SYSTEM, DETROIT, MI

Mr. BENFER. Thank You, Senator. I am David Benfer, Executive Vice President of Henry Ford Hospital and Group Vice President of the Henry Ford Health System. In that capacity, I chair an urban health initiative task force.

On behalf of the Henry Ford Health System, I would like to thank you for convening these hearings. Access to health care in southeastern Michigan and the growing numbers of uninsured individuals is at a crisis stage, and we need your help.

The individuals presenting testimony today are telling you their personal perspectives on why this country needs a national health policy. I have been asked to comment from an institutional perspective on the problems and the elements of reform you are considering.

The most important determinants for decency and vitality of a city, a State or a nation are the health and education of its citizens. In health care, we are witnessing a dangerous deterioration. The current problems are evidence of a major transition in health care which requires attention as we seek a broader and more permanent solution.

If I had to choose only one of a range of issues to focus on, it would be the lack of a comprehensive national health care financing policy and our diminished ability to shift costs from low-income patients to our paying patients.

At Henry Ford Hospital, we currently finance $14 million per year in uncompensated care or free care, and we will absorb an additional $16 billion in Medicaid underpayment and bad debts for a total of $38 million. This financial burden has increased more than 48 percent over the past 3 years.

In that same time, we have seen operating margins for hospitals in Michigan deteriorate, in many instances, to zero or below. The number of uninsured patients is increasing, and the absolute cost for providing care is increasing. Labor, equipment and facilities are all costing more.

At the same time, Medicare, Medicaid and other third-party payers, such as Blue Cross, have turned to fixed payments. At the present time, about 85 percent of our revenue base is fixed price, leaving only 15 percent available for cost-shifting. The result is a growing need for the charity care subsidy and a dramatically reduced capacity to finance it.

Our health care system has always had significant subsidies available to it for charity care and for excess capacity. Now, cost containment mechanisms have been designed to squeeze out that excess capacity and are also squeezing out our ability to subsidize charity care. This past year, Congress moved to protect the subsidy for unused capacity in rural hospitals by establishing a parity rate with that of urban hospitals.

Direct help for urban hospitals such as those referred to or described today with regard to charity care is also needed. Currently, the major public source of financing for the non-paying patient are the indigent care adjusters provided by the Medicaid program at the State level and the indirect medical education subsidy provided through the Medicare program at the Federal level. Both target extra payments for urban hospitals serving the poor.

Both payments are under attack this year. Governor Blanchard has asked the legislature in Michigan to reduce Medicaid payments by $65 million overall and has identified the indigent care adjusters for an approximate cut of $18 million.

President Bush is asking Congress to cut the indirect medical education payments by nearly 58 percent. Without benefit of a complete analysis of these proposals, we are estimating that the impact of that one decision for the Henry Ford Health System would easily approach $10 million in the year 1990-91.

Senator **Riegle**. That is $10 million you would lose?

Mr. **Benfer**. Ten million that we would lose; $10 million additional that we would lose.

The old system is broken, and the nation needs a new alternative. You are in the process of proposing a series of changes aimed at establishing a comprehensive national health policy. Your underlying assumption is that our poorest people will definitely need the support and assistance of our Federal government and State government. We agree with you on this issue. Health care is a basic right.

Unfortunately, people without health insurance do not have an organized constituency advocating on their behalf. Therefore, it is appropriate that Congress advocate on behalf of this group of citizens.

Turning now to the elements of reform that you are considering, we would support mandated health insurance for all employees and have specifically expressed support in the past for Senator Kennedy's employer mandated legislation. The combination of mandates and support for low-income employed individuals, either through tax incentive programs for small employers or through partial subsidy programs for companies at risk, are logical approaches to the employed population.

It also makes sense to mandate the insurance industry to develop risk sharing pools so that small employers would have the assurance of affordable coverage.

I believe it is appropriate for government to standardize benefits and mandate the basic services for primary care and in-patient hospitalization. The catastrophic costs could be pooled at either a State or national level and a separate financing program to cover these catastrophic costs could be arranged.

In terms of cost containment mechanisms, these services, in our opinion, should be provided through a managed care environment. Case management has demonstrated significant utilization reduction of high-cost services and the elimination of unnecessary costs. This approach is proving much more successful than cost controls and expenditure limits previously imposed through Federal regulation.

In addition, case management by responsible providers does not carry the negative incentives that we are seeing from past and present payment systems. The current approach allows cost concerns to interfere with access and quality. Quality and access make huge demands on cost.

There is very little opportunity outside of the management care system to have a balanced approach to all three issues.

All individuals should be covered by minimum benefits financed either by the employer or the government through tax incentives. Government help should be provided to our poorest population first.

Expansion of the Medicaid program by providing universal access for all individuals who are less than 100 percent of the poverty level and providing graduated subsidies for those individuals under 200 percent of the poverty level makes sense.

You have asked for a reaction to the question of Federal versus State initiatives. The more we look at this issue, the more cautious we become about centralizing a Federal program for everyone along the lines of Medicare.

We have found that health care is a local industry meeting local needs and local priorities. What is emerging in our internal and external discussions in Michigan is the concept of a regional system, like the Henry Ford Health system, one that is big enough to accept risk and responsibility for a defined population in a specific geographic region but small enough to focus on the local priorities and be accountable to the local community.

There are a number of activities we have undertaken in the way of trying to assess local needs and develop productive directions for health care services in our community. This past year, the Henry Ford Health System has initiated an urban task force composed of area health officials, health systems executives, other systems, Chamber of Commerce, The Medical Society, the Urban League and a number of your staff and a number of concerned Henry Ford Hospital physicians and staff members.

This task force is developing a model which not only intends to manage health care costs but also addresses the root causes contributing to the deterioration of health status in the neighborhood.

The model is for a defined geographic service area and would provide health coverage for all, through either employer mandated programs or public subsidy.

Participation in this program would require enrollment in a managed health care program. The plan designed would incorporate input from individuals living in the community, in order to establish the concept of the individual's responsibility for determining their own health status.

The population initially addressed will live in four contiguous zip codes surrounding the Henry Ford Hospital. We have some initial health status information and are investigating the possibility of measuring the impact of improved access in terms of health status indicators such as infant mortality, hypertension, diabetes, heart disease and others.

In addition, we are surveying our emergency room admissions to try and determine and better understand sources of payment, family size and other social and medical needs of this population. Approximately one-half of the total admissions for our hospital come through the emergency department, which amounts to about one-seventh of all visits to the emergency room.

Recently, we assigned a social worker for a three-month experiment to the emergency department to look at non-medical issues. This person was assigned to the afternoon shift and saw approximately 400 individuals, about 40 percent of them needing direct social service support for things such as housing, food, lack of heat, lack of electricity, just basic public services; 10 percent required direct placements into nursing homes and didn't need to be in the emergency department, and a number of them just needed assistance in figuring out the public assistance system.

Of the nearly 90,000 visits to our emergency department, we anticipate that approximately 20,000 probably do not need emergency department service but could be served in a primary health center. Through our task force discussions we have concluded that the sociologic components which are contributing to the deteriorating health status should also be addressed.

We need to address the educational programs in our community, the establishment of preventive health and lifestyle modification programs. There needs to be community collaboration for crime prevention and violence reduction on a neighborhood level. The establishment of job retraining programs to facilitate employment is essential. The establishment of housing rehabilitation so that we can stabilize the housing stock and support the homeless would be important; nutritional support for those who are in need, regardless of age, is another fundamental in the health cycle; day care for working families and, of course, accessible health services.

As Reed Tuckson, the Commissioner of Health for the District of Columbia, recently described it, health is the intersection where all social forces converge.

In addition, the Henry Ford Health System is making strides to organize services among our affiliated hospitals to meet access and cost concerns. We are increasing our managed care enrollment and strengthening vertical and horizontal integration of our health services.

We remain committed to the low-income population of Detroit and are finding ways to broaden our financial and philanthropic base in the suburbs to subsidize charity care.

It is all of our responsibility to make the necessary changes in the health delivery systems to ensure that accessibility to quality health care becomes a right; that health service is available in every geographic area; that the reimbursement system recognizes care for the uninsured; there incentives are established which require participation in managed care programs for Publicly-financed recipients and that new models of delivery are established in areas where high unemployment and limited access to services exist so that models address the root causes contributing to the deterioration of health status.

Health care is delivered on a regional basis by vertically integrated systems organized to provide cost effective care with an emphasis on continuously improving the quality of that service.

Senator, while this may seem ambitious, if we are to promoted dignity and vitality to our communities, we must begin by better understanding the problems and promoting practical solutions.

Thank you for the opportunity to present these views for your consideration.

[The prepared Statement of David W. Benfer appears in the appendix.]

Senator RIEGLE. Thank you very much. That also was an excellent Statement, and it starts to lace together all of the things that need to be considered as we put our plan together.

Let me now move to our last two witnesses, and after we have heard from them, I am going to have a brief interruption, a break, and anybody else who is here who wants to make a brief Statement will be invited to do so. If anybody has a Statement they want to give us for the record, we will take that, but I think anybody who has an observation or a suggestion or a comment or a story that they want to tell us, I want to afford that opportunity after we have heard from our last two witnesses.

I want to say now in moving to them that these are two of our most important witnesses. All of our witnesses are important, and it is always hard to be the last of the line for presentations. We have here Mr. Walter Maher, who is the Director of Federal Relations in the Human Resources Office of Chrysler Corporation, who really is one of the important, in my view, national leaders on the industry side in terms of large companies understanding and presenting some of the profound issues that are presented by this health care problem, and especially as it impacts our economic performance and our inter national competitiveness.

He will address, among other things, the high health insurance rates that are falling on companies that do provide health insurance, as Chrysler does, and he will be making some suggested policy changes.

He will be followed by Mr. Bob Lathrop, who is the political and legislative director for the Michigan State Council of the Service Employees International Union. He will be here speaking from labor's point of view in a sense, but also, specifically from the point of view of his role that I have just described. He will underscore the outlook and awareness and concern that is seen from within the labor movement itself as it has endeavored to secure health insurance coverage for members of organized labor at affordable levels and at sufficient quality levels.

They both have important things to say to us, and we are going to start now with you, Mr. Maher.

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, HUMAN RESOURCES OFFICE, CHRYSLER CORPORATION

Mr. Maher. Thank you, Senator Riegle. I very much appreciate the opportunity to share with you this morning our views on the problems health care costs pose for America, problems which, we have heard this morning, bear on fundamental equity for uninsured citizens and problems of affordability and competitiveness for business.

Americans spend about 40 percent more per capita on health care than the second most expensive country in the world, not than the average, but than the second most expensive country in the world. As a nation, therefore, we don't have to spend more money on health care. We are already spending too much. However, there is a great mismatch in how those resources are spent.

Public sector programs, as we have heard this morning, are spending way too little, and the private sector is massively overspending. There is virtually no health professional who does not readily admit to the existence of wastefulness in the delivery and consumption of health services in America.

Now, this massive over consumption of health services does not occur in a vacuum. There are three segments of our society that have been particularly hard hit. On the patient side of the equation—we have heard it this morning—tens of millions of citizens have either been denied access to the system or have been squeezed out of it' in large part, because of the cost of care.

On the payor side, small businesses, the majority of whom do offer coverage to employees, have been hit with staggeringly high cost increases and of ten lack the internal resources to soften some of these blows by negotiating favorable arrangements with PPOs and by otherwise engaging in specific health cost management strategies.

Further, insurance company administrative charges are often considerably higher for small business. The other segment of our society that has been severely impacted by the high cost inherent in the U. S. system are those businesses involved in international competition.

As you mentioned in your opening remarks, $700 of the cost of every U. S. built Chrysler car goes to support the U.S. health care system. We have included in our written Statement some exhibits that bear on that.

We must compete with foreign auto makers having a $300 to $500 per car advantage over us due to health costs alone. Now, business is quite limited as to what it can do in response to this problem, other than by discharging their responsibilities to manage their benefit programs as effectively as possible. It can't import a cheaper product from abroad; those involved in competitive markets like my own can't raise their prices at will to recoup higher health costs. Instead, what results is a classic squeeze on profits. Lower profits reduce the funds which would otherwise be available for investment in research and new products and job creation; lower profits also result in a reduction of tax revenues for investment by government in infrastructure improvement, including vital areas such as education.

The strategies that appear to be most in use by business are a combination of cost shifting to employees, managed care efforts with varying levels of success and other efforts to reduce labor costs by the automating or outsourcing of jobs.

How big is this problem? It is at least $100 billion a year. Now, while wealthier countries do tend to spend relatively more on health care—as they do on consumer items—than poorer countries, data has suggested that the United States lies well above the trend line, more than $400 per capita higher than it would be based on the average relationship found for other countries.

If we examine the health systems in these other countries, while they vary widely, we find they have two common denominators: They provide protection for all their citizens, and they have effectively established a process which provides some measure of control over how much of a country's resources its health system can consume. Both are key. You cannot do one without the other.

The vital element is coordination. Accordingly, Chrysler believes it is essential that the Federal Government participate actively with the private sector in developing a rational health policy for America. Acting effectively in its various capacities as the sponsor of public health progress, as a standard-setter and as a developer of tax policy, the Federal Government can help chart the course for such a policy which is so desperately wanting.

It can fulfill this role in only one of two general ways: Either by establishing the overall ground rules within which public and private sector programs must operate to accomplish our nation's health care objectives, including rules regarding medical underwriting, and we heard of those problems this morning; and the other way is for government to assume a more dominant role in the administration of this system.

I personally don't see any other solutions at this time which hold promise for success. The public and private sectors have to embrace a national objective to reduce the cost and improve the value of the U.S. health system. Inherent in this must be a commitment by the public sector to provide for all of society's poor and to assure that provider reimbursement for public program beneficiaries is fair and does not lead to cost shifting to private sector plans. Again, both of these features are key to avoid cost shifts. Not to diminish in any way the problems hospitals have regarding uncompensated care that you have heard this morning, but believe me, they do find ways to pass a lot of those costs on to their paying customers.

The federal government should also accellerate the introduction of managed care techniques and the adoption quickly of the physician payment review commission and other like recommendations as elements of both the Medicare and the Medicaid programs. Further, as a top priority, it should initiate reform measures to address the costs, quality and access problems caused by medical malpractice litigation.

A genuine problem does exist relative to those small businesses who currently do not offer health insurance to employees. If government wishes to involve them in the financing of our nation's health system, and I personally fail to see how we can rationalize any reform system where any segment of the economy is exempted from participating in the financing, then government must respond to the concerns of small business.

Most fundamentally, mandates in and of themselves are not only inadequate but would be wrong and counterproductive. It would be improper for government to mandate that an employer directly or indirectly offer insurance without at the same time assuring that the employer was buying into a rationally priced system and one whose annual cost increases were predictable. Thus, I would give such employers, indeed, I would give all employers, the option of buying in to a Federal or Federal-State community-rated program incorporating reasonable but tough managed care features and expenditure controls.

I submit that is very doable if the will exists to do it, and such a program would provide a model for private sector programs to try and better.

In conclusion, I believe it is important for the facts regarding our nation's health system to be exposed for the public to view. It is clear to me that the public does not fully understand how bad the problem is and how it impacts them, even if they have insurance. American citizens ultimately pay the total price for our health care system. We pay in the form if increased doctor bills, heftier insurance premiums and increased taxes.

The ability of our employers to increase wages is influenced. The prices of goods and services we buy are also affected. Citizens are also victims of a deteriorating national infrastructure, an inferior education system and many other indicators of a government strapped for funds, in part because of our nation's high health costs.

Worst of all, citizens are at risk of paying the supreme price of losing a job because their employer's business failed due in whole or in part to the unconscionably high cost of health care in America or because their employer automated or outsourced their job in hopes of reducing labor costs.

A business can do that. I mean, it can reduce health costs by reducing the number of employees, in short, by reducing the number of patients. A nation shouldn't have to do the same thing. The nation should not have to export citizens to reduce health costs, but nations do, however, export jobs, and that is what is going on in America today and what will continue to occur until we decide to take the bold steps necessary to make our nation's health system cost competitive.

Thank you.

[The prepared Statement of Walter B. Maher for the record follows:]

Senator RIEGLE. Thank you. That is a very important Statement you have given us. Let me just ask you, in your conversations with other major company representatives across the United States in the automobile industry and in other major industries that would represent large work forces of workers who have health care coverage, is the view you have just expressed today a widely-shared view among large companies in America that provide health insurance?

Mr. Maher. I wish I could say that it was widely-held, Senator. I think that you have, still prevailing in some elements of the business community, some gut reaction that, gee, they hate to concede the fact that there is some role for government in the solution.

It seems to me that sooner or later, those businesses are going to wake up to the fact that government plays a major role today in health care. I mean, governments, Federal, State, local, pay for about 40 percent of the health care delivered in this country, and the way those government programs are run, how much they pay, who they elect to cover and not cover, how smart they are in utilization controls, how freely they spend on capital expansion, medical education, all of that impacts the market that my company has to go to to buy health services.

It is just untenable to believe that all the bill payers in this Nation can go do their own thing and try to outdo the other, because as big as my company is, the Federal Government is a lot bigger and can drive a harder bargain and more importantly, the Federal Government has the ability to pass a law, which my company can't, and can say to a hospital, "take it or leave it."

So I think that there is a lot of learning going on very quickly today because the problem is so acute. Probably the biggest group that I think that has to come along here is the small business community, because the small business community, and there is no model of a small business community, but those that don't offer insurance are understandably paralyzed about getting into this ball game, because it is an awful thing to get into. That is why I say just to mandate them into it is almost cruel and unusual punishment.

You have to be able to demonstrate that they are getting into something fair, but the great majority of small businesses do offer insurance, and they are desperate. They are getting really rocked with year-over-year cost increases. I think that if we can get them involved in the debate that that will go a long way to break this log jam, Senator.

Senator RIEGLE. We had scheduled as a witness today Gary Woodbury from Lansing, who is President of the Small Business Association of Michigan who was not able to get here because of the weather. We are going to make his statement a part of the record.

[The prepared statement of Gary M. Woodbury appears in the appendix.]

Senator Riegle. It sounds to me as if, in answer to my question, some of the big companies see this problem the way Chrysler does. Some, yet, are somewhat grudging about it. They are finding it hard to, apparently, come to the same assessment of the problem that you have come to.

Mr. Maher. There are some efforts under way. The National Association of Manufacturers has a task force that I happen to be participating in that is hard at work on this, and I think in the next two or 3 months, frankly, is going to come to a final closure on the issue.

Senator Riegle. This is crucial, and I am going to be calling the companies before the Committee in Washington to ask them to respond as you have done today here so that we force the issue, as we will also be doing with small business and with labor. Because we are all in this boat together, and we have got to figure out the answer. people that haven't spent enough time analyzing it are going to have to get that job done, because it is time to deal with this thing.

I appreciate your comments.

STATEMENT OF BOB LATHROP, POLITICAL AND LEGISLATIVE DIRECTOR, MICHIGAN STATE COUNCIL, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

Senator Riegle. Let me now call on Bob Lathrop, who I introduced earlier. We appreciate the fact that you have been so patient in waiting for your turn, and we are very interested in what you have to say.

Mr. Lathrop. Thank you, Senator. For the record, my name is Bob Lathrop. I am the Political and Legislative Director of SEIU, the Service Employees Union here in Michigan. We represent 35,000 employees in the State of Michigan. Amongst those members, we also represent the largest union of health care workers in the State of Michigan. In fact, we have workers at Harper Grace and in approximately 175 health care facilities in the State of Michigan.

The creation of this bipartisan working group is very significant in our mind. We welcome your characterization of the issue as urgent, because we share that characterization, as well. We welcome your involvement in this, because you make things happen in the. U. S. Senate, and we definitely think that there is a need and desperately need something to happen on this issue of health care for all Americans.

I am pleased to have this chance to share with you the experience and perspective of SEIU on one of the historically key areas of union advocacy on behalf of our members, that being health insurance coverage. When the President of my international union called to ask me to be here, I knew that it was important. He serves as the chair of the Health Care Committee for the national

AFL-CIO and is looking, as you are, and everyone in this room, for a solution to this problem.

The labor movement has played a major role in developing the private insurance network that today covers some 65 percent of all Americans. But today's skyrocketing health care costs and declining access are fast destroying our employment-based insurance system. It is common knowledge, as many have pointed out today, that two-thirds of the 37 million Americans without insurance are full-time workers or dependents of these workers,

Less well known are the additional 40 to 50 million working Americans and their families who are finding medical benefits increasingly unaffordable. Run-away health care cost inflation is a prime culprit in this unraveling of employment-based health care coverage.

While more Americans go without routine coverage, troubling questions about the quality of medical care we get for our considerable investment are being raised. According to the National Leadership Commission on Health Care, and I quote, "As much as 20 to 30 percent of all things done by well-meaning physicians and good hospitals is either inappropriate, ineffective, unnecessary, and sometimes harmful."

Bargaining affordable family health care coverage for workers and low-wage industries has been an especially difficult task ever since the late seventies, but current cost trends are challenging the ability of union negotiators even to maintain affordable coverage established years ago for middle income workers and retirees.

For those of us in the labor movement, the health care crisis isn't just another policy debate; it hits us in the face every day at the bargaining table. During the first wave of double-digit cost increases in the early eighties, labor and management worked together to control costs through innovative cost control programs like mandatory second opinion surgery and hospital utilization review.

For awhile, such cost containment initiatives seemed to have a tangible effect in holding down inflation and employer-sponsored health plans while maintaining long-established levels of benefits.

But health care costs inflation is back. The average cost of coverage rose by over 20 percent in 1989. Effective cost containment programs are getting harder to find. Many employers have given up on attempting to control costs and are now simply interested in shifting the risk of health inflation to workers. Cost shifting disguised as cost containment is what is forcing workers in increasing numbers to put up picket lines. Communication Workers and the Mine Workers are the most recent and visible examples of this.

Last year, SEIU published a report that examined these trends through a survey of plans covering roughly one-fifth of our membership, which now totals 925,000 in the United States. Nearly 90 percent of the workers involved were on plans covering white collar jobs in State and local governments with relatively good wage standards and benefit packages, including family health insurance. That includes workers, for example, in Michigan that we represent in State government.

The study paints a bleak picture for the future of employment-based health insurance. Among the major findings : First, health coverage obtained through private insurance for middle income workers is in grave danger due to a sudden large jump in the employee share of the cost of such coverage. Worker premium contributions for family plans in our survey jumped 70 percent over the 2 years, double the average 35 percent rise in employer contributions.

Second, low wage service workers in the private sector are even worse off. For example, here in Michigan, we represent close to 10,000 nursing home workers. They average in the area of $4.00 to $4.25 an hour in wages. Although technically insured in some cases, less than half here in Michigan, their coverage is unaffordable.

The study finds that more than one-third of the disposable income of these workers would be required for premium contributions and deductibles alone, expenses which must be paid before insurance coverage even kicks in.

The survey results point out an important missing dimension in the health care access debate, and that is the erosion of private health insurance coverage isn't limited to the 37 million uninsured people in this country. Millions more have employment-based coverage only on paper. Workers increasingly find their health benefits unaffordable as employers push an ever larger share of the rapidly rising health costs onto their budgets.

Senator RIEGLE. Let me just stop you right there, because I think this is a very important point that deserves to be emphasized and underscored. That is you are seeing an erosion and a backsliding of health coverage by workers who in the past have had health insurance and that we, therefore, don't consider to be part of the 37 million with no coverage whatsoever. But you are saying that there is a new and serious erosion of coverage in that large category of previously covered, presently covered workers that we also need to examine and understand as part of this changing picture.

Mr. LATHROP. Exactly right. It is a story that really has not been heard by the citizens of this country at this point. In meetings with Congressmen, for example, on this particular issue, they are often surprised when union members walk in and tell them that, "Although we may have insurance, it is more and more becoming unaffordable."

Senator RIEGLE. If I may just interrupt you one more minute to say, the solution that we develop, I think, has to include a minimum benefit package. In other words, in addition to the principle of universal coverage where we take everybody and see to it that they have a method and a manner of health insurance through a variety of means, if not a single means.

Then at the same time there has to be a minimum benefit package that is spelled out that, in a sense, creates the basic core of health protection. I would like the ideas of any and all with respect to what constitutes that basic bundle of minimum health insurance benefits that should be universally in place.

I would just ask anybody that will to help us think that through by perhaps adding an addendum to our committee record today so that we could have that in writing.

Mr. LATHROP. We would be happy to do that. We definitely have some ideas in that regard, and I know that our union, which sat with Mr. Maher and others on the Governor's Access Committee, discussed that issue as well, and I'm sure we could pull together a proposal for the committee.

The trends that I spoke to, the two trends, more jobs without insurance and more jobs with unaffordable insurance are rapidly destroying the private insurance base of our country's health care system. The labor movement will continue to bargain aggressively to hold the line on health benefits while working with management to achieve genuine cost savings.

But we recognize that it is not the long-run solution to our nation's health crisis. That is because the roots of our inability to rein in health care costs lie in the multiple financing mechanisms that characterize the U. S. health delivery system.

With thousands of public and private health plans, cost containment amounts to little more than each plan trying to shift those costs elsewhere in the system. Meanwhile, the Federal government is busy shifting its Medicare costs to retirees or employers. By bearing down on hospital costs, Medicare has now shifted much of the care for the elderly to the outpatient side. Under part B, seniors or the former employers of those with retiree coverage are responsible for 20 percent of the bills.

In turn, employers saddled with skyrocketing costs and new corporate accounting rules that threaten their bottom lines are looking to get out of the retiree health business altogether. So they are shifting their rising costs to retirees through higher co-pays and fixed caps on their contributions, reducing coverage by requiring longer service to qualify and ending benefits for future retirees.

Of course, employers without health coverage for their work force are getting a free ride, shifting their costs to everybody else. It is a vicious cycle. This deepening crisis in health care is forcing consumers, purchasers, and even some providers to speak out on the need for change, for a solution to the American health care dilemma. Unfortunately, there is no consensus yet on what these policies should be.

During the 1980s, Congress has addressed access to health care in a piecemeal fashion. The battle of the budget may dictate continuation of this approach. SEIU continues to support incremental efforts such as the expansion of Medicaid coverage, but further and different action is also necessary before the private insurance system collapses.

We believe further action is needed both to control costs and to improve the quality and appropriateness of care. We need to plan to move quickly to ensure universal access with effective cost control the new standards of quality assurance.

We need, in short, systemic reform carried out at the national level. In recent months, a host of comprehensive U. S. reform initiatives have surf aced ranging from public-private partnership models such as the National Leadership Commission on Health Care and the voucher-based system advocated by the Heritage Foundation to Canadian-style national health insurance proposals from a physicians group and the Committee for National Health Insurance.

We urge the committee to weigh all the reform proposals which are now being put forward and to bear in mind the lesson of labor's experience in recent years: That private insurance, arranged on a voluntary basis, is falling substantially short of the mark.

The direction taken has important budgetary considerations. Currently, significant expansion in Medicaid eligibility alone would add significantly to the Federal budget deficit, as low wage employers would dump their workers onto the public rolls. Similarly, without Medicaid expansion, employer mandates alone are problematic. Unless co-payments and deductibles are picked up by Medicaid, the high levels of stop loss in mandated minimum health benefit proposals will recreate the access problem for low wage workers. Furthermore, some Americans have no ties to the work force.

An alternate approach lies in a modified Canadian-style system with government-based financing and two-thirds of Americans favored moving to a Canadian-type system. The appeal lies with Canada's combination of unqualified, universal access and the ability to control costs at the same time.

The efforts of this Senate Finance-Labor Working Group, led by you, Senator, are moving in the right direction. The public-private partnership approach builds on what exists while clearly calling for universal access. At the same time, the working group is emphasizing the need to develop systemic cost containment mechanisms. Out of control costs are what is driving the access problem and undermining our job-based system of health care coverage.

The present moment requires strong leadership to steer us out of the dangerous cross currents and to fashion a national plan to solve the triple problems of declining access, high costs and uncertain quality.

The call for national reform is being echoed in many corridors, including this room. Now is the time to turn the growing consensus for national reform into a plan of action. We are hopeful that this working group is the body in which to do that, and we thank you for your efforts.

[The prepared Statement of Bob Lathrop appears in the appendix.]

Senator RIEGLE. Thank you very much. Let me say that John Sweeney, your International President that comes from our State, has given important leadership at the national level within the labor movement, as Chrysler, your partner at the table there, has done on the business side. We greatly appreciate them in both instances.

I want to just make one or two summary comments, and then we are going to take about a ten-minute break. Then I am going to invite anybody else who has comments or observations they want to make to do so, so that we can complete the hearing record.

I want to make two or three observations. First, I myself am very impressed by the size of the audience that we have had here today, given the terrible weather. In fact, everything is shut down all over the place, the schools and everything else. The fact that so many of you have come and remained throughout this hearing, I think, underscores the importance that it has. I know on a good weather day, we would probably have a full room here.

But I think we, in a sense, have a full room in terms of the intense interest of those of you who have come, many from a great distance.

Secondly, I would say that the testimony that we have gotten today has really been exceptional, I think, both in terms of looking at this through a number of facet points, but also, allowing us to aggregate inside information about the scope, the scale and the make-up of this problem that really moves us much further down the road toward devising an answer to it.

Thirdly, the proposals that I am asking you to react to here in terms of the options and the parameters of the ways to deal with this problem. It is very important I get a response from all who are in a position to respond to that, because we are going to move ahead, both within the bipartisan task force, and I intend to, as the chairman of the subcommittee, to put forward a proposal and to do it soon to get it out there and to get the national debate going and to try to force action sooner rather than later.

I think we have an opportunity, as I said earlier, as a State to play a particularly important role in this National debate and national change that now must come. We are positioned as a group to help spearhead that effort. We are, through this subcommittee, and through the know-how and the points of view that were represented by witnesses that we have heard today and others that we have also heard from, and whose views we solicit.

So I want to thank, again, our witnesses who have come, some from a great distance, to provide this exceptionally good hearing record today. I want to acknowledge, as well, David Krawitz, my Administrative Assistant, who is seated to my immediate left here, and Debbie Chang, who is on my right, for their outstanding work and leadership over many, many months now in the health care area. This is a driving interest of theirs, as it is of mine. It takes hundreds of hours of dedicated work, along with other staff members who are present around the room, to put us in a position collectively, all of us, as a group, to really get to the bottom of what is happening, figure out what to do about it and then mobilize a response to the problem.

So I appreciate their efforts and the very important part of the work that we are doing. With that, I am going to declare a brief recess here. I know the stenographer will be sorry to hear this, because I know she would like to stay there and keep typing, but she has really done and exceptional job, including getting here from Chicago to be present at this event. She is the official person designated by the Finance Committee that takes great care with producing these transcripts because of the importance that we attach to them. I appreciate her hard work and I am sure she can get use a brief respite here as some of the rest of us might.

So let us adjourn here, recess for about ten minutes or so, and then I am going to invite anybody else who would like to come forward and make a comment to do so. We will try to keep those within a five-minute time period so that we can accommodate anybody that wishes to speak. With that, we will stand in recess for ten minutes.

[Brief recess.]

Senator **Riegle**. Let me just call us back to order here. I had some questions from some of the press people present outside, and I had to take a minute to respond to those.

We have got two or three individuals that have indicated they would like to speak. First of all, I have a formal Statement from the Michigan Association of Ambulance Services, and we are going to make their Statement a part of the record. I do so at this time.

[The prepared Statement of Brian P. Lovellette appears in the appendix.]

Senator **Riegle**. Mr. Jerry Grubb of Bloomfield Hills has asked to speak, and he is here in behalf of the Michigan Association of Ambulance Services. He would like to make an oral comment in addition to the Statement, and I invite him to do so.

Mr. Grubb, if you want to come on down and take a mike. We are pleased to have you here. We are interested in what you have to say. Why don't you just take that chair and what I am going to do, is, let me just inquire. Are there others in the audience? This lady would like to speak. This gentleman would like to speak. This lady would like to speak. I see five or six others. Why don't we try to limit the period of time for comment to about three to four minutes, if we can, so that we can accommodate everybody that might like to speak.

Mr. Grubb, why don't you start.

STATEMENT OF JERRY GRUBB, MICHIGAN ASSOCIATION OF AMBULANCE SERVICES, BLOOMFIELD HILLS, MI

Mr. **Grubb**. Sure. Senator, thank you for inviting us to speak at the hearing here today. I am Jerry Grubb. I represent the Michigan Association of Ambulance Services, which is a Statewide organization representing ambulance and pre-hospital care providers. I am presenting our views today both as health care providers and as small businesses that face the same problems as other small businesses in providing services.

We are concerned about the effort to expand the Medicaid program, because our current reimbursement through the Michigan Medicaid program is not adequate to cover the cost of providing service. We are the only provider that is required by law to provide service regardless of the patient's ability to pay. Thus, Michigan's ambulance providers are caught in a double bind.

We are paying to subsidize the Medicaid program as individual taxpayers and as small businesses. We are required to provide additional out-of-pocket dollars each time we transport a Medicaid beneficiary because the level of reimbursement for ambulance service is considerably below the true cost of providing the service.

To expand this program without significant improvement in the reimbursement to our industry in Michigan would add an increased financial burden, where there is already hardship and where many of the rural areas are unable to afford and maintain the standard of pre-hospital care that best impacts the morbidity and mortality rates.

As small business concerns, we strongly support efforts to assist us in providing comprehensive health care coverage to our employees, while being cognizant of the financial feasibility of such efforts.

It is important to note that efforts to control health care costs in the long term may best be focused on our industry, because early intervention through the prevention of quality, free hospital care could be the best health care bargain available today.

The appropriate management of an airway or immobilization of a fracture and other treatments of disease in a pre-hospital setting will frequently prevent expensive long-term care and rehabilitation.

As an association, we support your efforts in dealing with this very difficult problem, assuring all Americans access to quality health care in the most cost-efficient manner.

Thank you for your time.

Senator RIEGLE. Thank you very much for coming and presenting this. Many of us in the room have had the occasion to need emergency ambulance service, and boy, I will tell you, when you need it or a member of your family needs it, it is worth its weight in gold in terms of saving lives and getting people in for the care that they need.

I appreciate your comments and we thank you for coming to testify.

Mr. GRUBB. Thank you.

Senator RIEGLE. I think I saw this woman's hand first. Would you like to go next? Do you want to come on up and identify yourself. Let me also have David go down, and let's identify who else is going to be speaking and get the names so that we can have an order in which we can take people. David will come right down right now. Why don't you meet him in the back, those of you who wanted to arrange to be called on here.

Why don't you tell us who you are, where you are from, and then we would be pleased to hear from you.

STATEMENT OF DELORES HOWELL, PRESIDENT, ALLIANCE OF THE MENTALLY ILL OF MICHIGAN, OAKLAND COUNTY

Ms. HOWELL. Thank you. My name is Delores Howell. I am from Royal Oak, Michigan, and I am President of the Alliance for the Mentally Ill of Michigan, Oakland County.

I would like to include testimony in this hearing regarding the automatic discrimination of those who need health care for chronic mental illness. The practice of limiting hospitalization to 45 days is discriminating and can lead to an unfair burden on the families of those who suffer mental illness who need more than that amount of time of care.

It has also been the fact that our son was denied in-hospital care as he was told he had exhausted his life time in-hospital benefits of a policy he was paying for as an employee of the U. S. Postal Service, and he was only 34 years old.

He had held this job as a letter sorting machine operator for 13 years. He had been diagnosed as having bipolar effective disorder, more commonly known as manic depression, and controlled with Lithium therapy.

As a government employee, he paid 40 percent of his premium cost of his HMO insurance. Because of the stressful nature of his job, especially during the holiday season, he required in-hospital care for a couple of weeks approximately every other year to stabilize his condition and to return to his work.

In 1987, he was informed he no longer had in-hospital benefits and could only use the office care of the HMO psychiatrist. When he left, his relief levels needed to be checked, as he seemed more agitated. I was told to wait for a month.

Within that month, his condition deteriorated, and he was hospitalized at Clinton Valley Hospital, the State facility. He subsequently applied for a medical retirement from the Post Office, and it was granted.

Now, as a retiree, he still pays for his own health care insurance premiums out of his pocket. But it does not include treatment for his mental illness, only physical illness or accident.

He still uses the county system to control his symptoms and is able to live out of a hospital setting. In fact, he is now a student at a local community college studying for a less stressful career as a pharmacy assistant. But the fact stands that there is blatant discrimination of chronic mental illness in all insurance policies.

Thank you.

Senator RIEGLE. Thank you very much. I think that is an important Statement. I have seen a number of cases like your son's case, and I think this is an area where there is a real gap and where preventive medicine can make a real difference. Thank you very much.

STATEMENT OF RUTH GIFFORD, OAKLAND COUNTY ASSOCIATION FOR THE MENTALLY ILL, OAKLAND COUNTY, MI

Ms. GIFFORD. My name is Ruth Gifford, and I am here with Mrs. Howell as part of the Oakland County Association for the Mentally Ill.

For many of our children, people forget this is an illness, and it is not limited to 190 days, as defined by Medicare. That is all you get from Medicare. It is all written out, life time care. Many of them have to go back and forth to the hospital for a variety of medical adjustments but may not be in critical care, and the State facilities are limited to critical care patients only.

In short, you cannot get into a State hospital unless you are under critical care. The Community Health Services cannot admit because it is against the law for them to admit to a private hospital. The only way you can get into a hospital if you are uninsured, uninsurable or your Medicare has been exhausted if you have been ill any length of time past the 190 days is to qualify for Medicaid.

Many of these patients can function out of the hospital and at a part-time job or a job that will take them off Medicaid. They do not get Medicaid.

So they are not insurable; they can't buy insurance; they can't get insurance, and they are chronically uninsured.

If we can get the patient in, we have to have a private doctor on a private hospital staff, because you cannot go into Sinai, Beaumont or Providence on your own. You must be a patient of somebody; a doctor on staff must admit you. They will admit under Medicaid at Medicaid rates in a Medicaid participating hospital. But if you aren't on Medicaid, you have to figure out how to qualify for Medicaid.

This information is not available to us. It seems to be a secret kept by the State. I have looked all over to get a Medicaid manual and place it in our library so we understand the rules and regulations of Medicaid. That is our insurance of last resort.

Senator **Riegle**. We are going to get you a copy of it. I just told Debbie to make sure.

Ms. **Gifford**. We want this placed where we have a reading room so we can pass the information around——

Senator **Riegle**. Absolutely.

Ms. **Gifford**.—to each other. There is one thing about Medicaid: If you can get it, at least they cover psychiatric wards at a private institution, and sometimes you need just two or three weeks, which you may not need, and you don't qualify for the State life time critical care unit, and they [illegible] to bar you out of there, anyway. That State policy is to keep [illegible] out, you know, in every State. So you can't get the help through the State mental health system or the county mental health system.

So we have to use Medicaid as a last resort and hope to find a doctor that will take us in. We need the information available to us. It can't be hush-hush. We can go to the Oakland County Law Library and read Federal law all we want, but we cannot get the State qualifications.

Senator **Riegle**. We will get it; we will get it for you.

Ms. **Gifford**. We do appreciate that, because it will be a help, and we do want you to remember that mental illness is one of the illnesses that is never covered by private insurance. It is always limited or you can't get it. It is a pre-existing condition, so even if you do get better and you can get a job, you still don't get it.

Senator **Riegle**. Thank you. Those are very important points, and I appreciate your putting them in the record for us.

Ms. **Gifford**. Thank you very much.

Senator Riegle. Gus?

STATEMENT OF GUS BIANCHINI, CHAIRMAN, WARREN SENIORS, WARREN, MI

Mr. **Bianchini**. How are you doing, Senator?

Senator **Riegle**. Good to see you. Nice to have you here. Why don't you identify yourself for the record and start in.

Mr. **Bianchini**. Yes. I am Gus Bianchini, Chairman of the Warren Seniors. That is a group here in the City of Warren that we have with over 3,000 members.

Number one, we want to welcome you for stopping here in the City of Warren, Senator, and addressing this vital problem which concerns the seniors of all of the country.

From a population of 150,000 people living in the City of Warren, over 40,000 are seniors, and we have an outreach program in our group that the calls are coming over that the people with health problems are really flooding us. Every day we get a call addressing these problems of they can't pay their hospital bills, hospitals letting them out right after they have a major operation or in just three or four or 5 days they are home.

That is the problem that we are trying to address to you. Most of the seniors in our group, and also the seniors that I have met in the City of Warren are not asking for a free ride, okay? They want to pay their way. If we can come up with a program, a national plan, a program that will institute all of the 39 million seniors in the United States, we are willing to pay some part of that program. I mean, it is getting to be today with the 37 million that haven't got insurance, it is a shame.

Only two industrial countries in the world, the United States and South Africa, don't carry insurance of any health form for their citizens, and it is getting to be a problem. We would like to volunteer our group and our membership to you, Senator, to start a grass roots program for a national health plan. If we have to have support, you are welcome to it. All you have got to do is just call on us.

Senator RIEGLE. I appreciate that.

Mr. BIANCHINI. Thank you. Also, in closing we want to thank you again for stopping here in the City of Warren, and anything that our seniors here in the City of Warren, all 38,000 of us, can help you with, you are welcome.

Senator RIEGLE. Thank you, Gus. That is a very helpful Statement, and I appreciate the fact that the seniors are willing to get behind and push on broadening the coverage out so we can cover everybody.

Jackie?

STATEMENT OF JACKIE SKOWRONEK, ALPENA, MI

Ms. SKOWRONEK. Right here, Senator.

Senator RIEGLE. Let me hear you pronounce your last name.

Ms. SKOWRONEK. Skowronek.

Senator RIEGLE. Why don't you come on up there, take the mike and introduce yourself to the stenographer.

Ms. SKOWRONEK. My name is Jackie Skowronek. I am from Alpena, Michigan, and at this point, Senator, I am testifying as an individual, not as one of my groups.

In listening to all the testimony today, and I really appreciate your all inviting us here today, and I am looking forward to when you come up to the Gaylord area——

Senator RIEGLE. What that is a reference to is, she was saying earlier that it is important to have a hearing in northern Michigan in a location that is centralized that people could get to from Alpena and Traverse City and Gaylord and other places up in northern Michigan. She was so right when she said it. I said, "You have got to deal. We will do such a thing in Gaylord," which we decided was probably a good central spot, so that is what that makes reference to.

Ms. SKOWRONEK. I have listened to all the testimony here, and I think Cheryl's family did a fantastic job, and so did Arlene's husband. But one of my concerns is no one on any of the panels addressed a couple of things.

One thing we do need to do is educate people of your age, even, and younger that if you are employed and you have a husband-and-wife situation, whether the wife works or whether she doesn't, if the husband is covered under an insurance policy for health care, what happens to the wife if something happens that the husband passes on? How do you insure the widower's spouse? Because they don't any longer belong to a group.

Another question that I would like entered into the record is: Why do the States' poverty levels throughout the fifty States vary so drastically from the national poverty level? As you know, in the State of Michigan, our poverty level is listed Statewide at 125 percent. The people that are snow birds and go to Florida have the world on a string down there, because it is approximately 165 percent. So they get more benefits in Florida in the winter than they do in Michigan in the summer.

After listening to Cheryl's sister there earlier saying where Cheryl had been employed by 7-11, which is a national and worldwide, I guess, organization, the same as McDonald's, why can't the higher echelons somehow give them an incentive? Because each one of these two groups, most of the stores are franchised out, so it is the small business; it is not the worldwide conglomerate. Give them some type of a better incentive to give their employees an opportunity of affordable health insurance, even if they have to go under McDonald's or the Southland Corporation group to get those franchises insurable.

Senator **Riegle**. Let me just say to you that you are exactly right on that, and that is part of the plan that we are developing. Your reaction to it is helpful to hear, because you are right. Many of these companies are small franchises, and we have got to have an incentive system. There is a lot of efficiency and value in having employers provide health insurance coverage, presuming that we can work out an arrangement where they can afford to do it and it is efficient and that there are the right incentives in place that enable that to happen.

It is complex to do that, but that is part of the answer to this problem. We see that as part of the answer, and we are going to try to craft that into our package.

Ms. **Skowronek**. Fantastic.

And then another question, since I am covered under Medicare only, since my husband's demise, from my understanding, Medicare will not cover a once-a-year physical as a preventive measure, and I always thought an ounce prevention was worth twenty pounds of cure, so I think that needs to be addressed in our proposal of corrections along the way.

I heard some other people testifying about homelessness and so on and that you couldn't get assistance. If you don't have an address, you can't get any form of help, whether it is food, shelter, medical assistance or whatever. If you can't get assistance, how can you get an address? And that is not just Statewide. That is in your front door in Washington. Within a block of the Capitol, you have homelessness. So I would appreciate that be addressed, as well, because there is no way you can get medical help if you have no address.

As the hospital and emergency technicians were testifying, right now, I am scared to drive out of here, to be perfectly honest, after listening to their testimony, that if I have a car accident and all I have got is Medicare and I am taken to the wrong hospital, I won't be treated, is what I'm hearing, and that is scary.

Senator **Riegle**. That is one of the reasons we are having the hearing.

Ms. **Skowronek**. So I would like to say thank you for this opportunity, and I will look forward to your coming up in our area. Please, get this going sooner. Thank you.

Senator **Riegle**. I appreciate what you have said. I should just say to you, you mentioned the problem of homelessness. This is also an area that we have really been zeroing in on. I have formed a task force in the State of Michigan, and we now have groups working in 26 areas of the State to really collect the facts we need to know on that problem. I have been visiting a number of homeless shelters and homeless groups in different areas of the State.

In fact, I was doing that earlier this week in the Detroit area. In fact, we just started the renovation work on a shelter for families out in the suburban Wayne County area. Ed McNamara, the County Executive, has really given very important leadership in the local communities to get some leadership together, and we put some Federal money in, and we are going to do something in that area.

But the homeless problem is a very serious problem and a growing problem, and the complexion is changing. We are seeing more and more families. We are seeing more and more single parents. We are seeing a lot of mothers with children homeless and with no place to go. As you say, if you don't have an address, it is very difficult to qualify for any kind of a benefit to try to get back on your feet.

I had a situation the other day. I will share it with you in the spirit of the meeting that we are having here, because it was as powerful in its own way as Cheryl's story. We were visiting a homeless shelter down in Detroit. This is about a month ago, and they had just rehabilitated this building. You can only go in for 30 days, as you know, and then you have got to find a place. There could be an extension under certain circumstances. I was talking to this one homeless mother who was there. I didn't know the facts in her case, but as I spoke with her, I found out that she had this little bundle of blankets beside here, and in it was a baby girl that was 5 days old.

She had the child. She was out of the hospital. Here was the child, and she was obviously, the mother, not in very good shape or strength right then because of the fact that she just had the baby, not to mention the condition that the baby might be in. She had a little two and a half year old son sick with a fever. He was sitting on the floor there, and you could feel his head and feel how hot he was. He was coughing periodically and so forth. There was a snowstorm outside, and I would say the wind chill was probably about ten degrees or less. I mean, it was a miserable day, and the wind was really strong.

She was about to take herself, the five day old baby girl and her sick little boy down to the bus stop and wait for what she told me was normally 45 minutes to an hour for the bus to come so she could get on the bus and go to the social services, where she would end up spending most of the day with these two little tykes trying to go through the procedures that have to be done in order to try to establish a way to get out of the situation that she was in.

It was such a powerful experience, and you wonder what the country is thinking when we have got people, anybody, even a single family or children like this, let alone tens of thousands of them scattered all over the place in these kinds of circumstances. It is as if they don't matter; it is as if we don't care about them because we don't know them and it is their problem, and not our problem and so forth.

There is a happy ending to that story in the sense that we were able to help that particular woman and she is now in an apartment with her children and they are coming along. But there are a number of cases out in the homeless community.

I happen to be the chairman of the Banking and Housing Committee in the Senate, so about half the Federal money that comes into housing programs for the homeless comes through our committee.

I am taking it a point to understand exactly what the nature of that problem is and how well or poorly we are meeting the problem and so forth starting in Michigan, but then trying to figure it out around the country. So we have been spending a lot of time on it. But your point is so well taken; that is, that if you lose your job or you get sick or your husband or your wife dies and all of a sudden you have had a financial setback and you are out of your house or you are out of your apartment and you are a homeless person. It is very, very difficult to get out of that situation and get back into a stable situation. We have got so many people out there.

I was down at the Capuchin Father's kitchen that they maintain in Detroit, and we were talking with the people that run it about how many meals they are serving and who they are serving them to. The numbers of people have just skyrocketed, but the priest down there was saying that so many of the people that they are feeding now are young family people with children. As I looked around the room the day I was there and talked with some of the people, I was astonished of how many kids were in the room, kids a few weeks old, few months old, two, three, four, five, 6 years old. You sort of say to yourself, "what is happening to these children, and what does the future look like?"

I mean, here is part of the face of America in terms of these kids that are in this situation, and you say to yourself, "what chance do they have to ever get a handhold in life the way things are working today? How do they get any kind of a stable situation? How do they get to school? How do they get their health care? If they need glasses, how do they get their glasses?"

That is a big problem to address in this country.

Ms. **Skowronek**. I can add one comment to something you have already said. How can we? One thing might be to check into the welfare system, which is beautiful to a point. It penalizes people that have to be on it. If they go out and take a minimum wage job, they lose any kind of assistance that would make them be a productive person.

If they are taking that minimum wage job, at least they are paying back into the system, and at the rate it is going right now, they lose their health care; they may lose their food stamps, which would be something that they at least are paying back into. So that is something that I think should be addressed, also.

Senator **Riegle**. Interestingly, you are exactly right, and we, in fact, have just changed the Federal law. I was able to write this change along with Senator Dole. We worked together on this with people who are handicapped or have a disability and who could, nevertheless, find a job but before they have the job, if they qualify for Medicaid because of their disability, do they lose their coverage when they take the job?

Of course, if they do, then they can't afford to take a job, which means that they would be working, earning, contributing and so forth. We were able to change that law to allow them to, in those cases, take the work and maintain coverage.

So that is just one step. As you say, we need to broaden that so that people who can find work and hold body and soul together have a positive incentive to do so and can come out ahead.

Ms. **Skowronek**. And I understand what you just said, that it is like a disabled person——

Senator **Riegle**. Yes.

Ms. **Skowronek**.—mentally or physically can still keep their Medicaid.

Senator **Riegle**. Right.

Ms. **Skowronek**. But an individual who is healthy that takes a minimum wage job that might qualify for it that is on welfare would lose their Medicaid.

Senator **Riegle**. That is the way it is now.

Ms. **Skowronek**. I just wanted it clarified.

Senator **Riegle**. We have taken one step in the right direction, and the step we have been able to take is with the person who has a disability who is sort of struggling with even a further problem. We have established the principle.

Ms. **Skowronek**. Congratulations.

Senator **Riegle**. We not only helped that group, but we established the principle. That just happened within the last year. How many people did we anticipate that would affect either in Michigan or across the country, the numbers?

Ms. **Chang**. There are four million people on SSDI who could potentially benefit from it.

Senator **Riegle**. Yes, there are four million across the country who qualify for Social Security Disability who would be in a position, if they can find work, that they would not, therefore, lose their health coverage. For many of them, it is critical, because they already are struggling with a problem, and very often, they are very vulnerable health-wise. So if you take away the health protection, you have really destroyed their incentive to work, if that is the first cost they have to incur.

Ms. **Skowronek**. Sure.

Senator **Riegle**. But by correcting that problem, we now, I think, have laid the foundation for being able to, in due course, raise the issue and pursue the issue with respect to other people who are able bodied who also should be having a constructive incentive to work. We wanted positive incentives to help get people back into the game. What is so ironic is most people want to be in the game. People are desperate to get into the game. It is not that they don't want to work; it is that they do want to work, but so much of what we have is geared against their being able to do so and still hold body and soul together.

Ms. **Skowronek**. They are penalized if they do work.

Senator **Riegle**. Thank you.

Ms. **Skowronek**. Thank you, and congratulations on that legislation.

Senator **Riegle**. Thank you very much. Mike Malley?

Ms. **Howell**. Is that the Americans Disability Act that you referred to? No.

Senator **Riegle**. It is called The Social Security Work Incentives Act.

Ms. **Gifford**. Will this apply to Michigan Medicaid?

Ms. **Chang**. Yes, it would.

Ms. **Gifford**. I sure hope we get the manual, because I don't think it has been implemented yet.

Ms. **Chang**. It was recently enacted, in October 1989.

Senator **Riegle**. This just happened, and so the wheels are turning, but we will get that information to you.

Ms. **Gifford**. Because that would be very helpful.

Senator **Riegle**. That is why we did it. Actually, it sort of happened without a lot of fanfare, we got it done; partly we got it done because we had a good, bipartisan team and we didn't do it secretly. We spent more time getting it done than talking about it, so now that it is done, it isn't widely known.

Ms. **Gifford**. That will help a great deal, because many of our sons and daughters could work part time or little time or some of the time.

Senator **Riegle**. That is right. That is the whole idea.

Ms. **Gifford**. But not forever, and maybe not under the greatest, most stressful job, but something, and they feel better.

Senator **Riegle**. Oh, it is such a help to the mental health of a person who can go and do something and have an outlet and make a contribution.

Ms. **Gifford**. For our son, it is his therapy. But every time he does it, he loses his Medicaid. There is $150 of medicine. Then you are off your medicine and you are back in the hospital. That is the way it has been.

Senator **Riegle**. We think we have fixed that problem, so we will get that information to you.

Ms. **Gifford**. That is great. Nobody told us.

Senator **Riegle**. Mike, you are next.

STATEMENT OF MIKE MALLEY, PLACEMENT COORDINATOR, RAINBOW TREE CENTER, YPSILANTI, MI

Mr. **Malley**. Thank you, Senator.

Senator **Riegle**. Do you want to identify yourself?

Mr. **Malley**. My name is Mike Malley, and I live in the City of Royal Oak. I work in the City of Ypsilanti at a company called

Rainbow Tree Center, which provides rehabilitation therapy for people recovering from head injuries.

I really appreciate the opportunity to be here today as part of this hearing, and I wanted to talk about an aspect of health care that I don't think has been touched upon, and that is the area of post-acute rehab. On a broad scale, I am thinking of many people in our society, senior citizens, for instance, that might have suffered a stroke that would require a type of physical therapy or occupational therapy to regain the use of a limb, perhaps if they had a paresis on one side of their body.

More specifically, I wanted to talk about citizens that are classified as brain injured, and I have prepared a script here that I will read from. A brain injury is something that causes memory loss, impulsivity, personality change, the inability to make decisions, fine motor skill impairment and hand-to-eye coordination impairment, just to name a few.

Needless to say, the effects of a brain injury can be devastating and often result in a person losing their job. When a person suffers such an injury, they require acute medical treatment in a hospital. Once physically stable, the patient requires rehabilitation therapies to help them gain back their functional independence.

Presently, in Michigan, because of auto no-fault insurance* many people receive the post-acute rehab which they require. This provides them the necessary care to return to society as a contributing citizen as opposed to becoming a ward of the State.

My testimony here today is twofold: First, to assure that the present no fault automobile insurance system remains intact and not be changed. This is in reference to the Michigan Senate Bill 712, which seeks to revamp our present no-fault system.

Secondly, that those people, and I don't have the answers for this, but those people that suffer a traumatic brain injury that is not motor vehicle-accident related somehow or another, just as the senior citizen that doesn't have the insurance for post-acute rehab, receive the type of therapies to which they are entitled as a citizen in our country.

Thank you very much.

Senator RIEGLE. You know, that is a terrific Statement, and I appreciate your saying it. This is another area where we have been at work. In fact, I have written a bill that would require all Social Security Disability beneficiaries to receive rehabilitation and to have the opportunity to come back from whatever the problem is, whether it is a stroke, an accident, or what-have-you. We are pushing that this year.

This is a main area of interest of mine, and we are chipping away, piece-by-piece, in getting at these problems that have been ignored for a long period of time and where people have been ignored and sort of shunted off to the side.

I will just tell you a little personal story, if I may, in the spirit of the informality of our gathering here now. My father-in-law, many years ago, was up in Reed City, Michigan, which is where my wife grew up, and was the manager of a plant up there, a Garden Denver manufacturing plant. He had a terrible stroke. He had come through the war. He had been through combat in the war, and he had come through that in fine shape and everything, but 1 day, bang, he went through a terrible stroke and lost his ability to speak and certain other functions. Some he retained; some he lost, which is often the pattern, as I am sure you have seen in various cases.

Fortunately, because he was a Veteran at the time, he was able to go to the speech therapy clinic at Michigan. He was there longer than anybody else had been so they could try to teach him to speak from the other side of his brain, because the part that normally controls speech just didn't work properly. It took a very long period of time. It was very difficult, but he made progress and finally was able to develop enough skill that he was able to come out and go back to work.

What was very interesting, his company at the time was good enough about it—some are, some aren't—that while he had been manager of this plant, he couldn't do that job any more. So they give him the job on the lowest rung of the ladder. He went from the top job to the bottom job, but nevertheless, he had a job. He was able to go back into the work site and then work for the next couple of decades until the plant, unfortunately, closed recently and everybody in the plant lost their job, including him, principally, to imports.

It is a common pattern. But it is so interesting. I have seen hundreds of cases like this. I cite that case because it is one that is very intimate and very familiar to me. This was a family that the mother was a nurse, fortunately. She was able to go to work. They had four little ones. My wife was the oldest child at the age of four at that time, so she became an officer of the deck for the three younger ones. If her father had not gotten rehabilitation and had the chance to go back and re-establish himself and maintain his work life, I don't know what they would have done as a family in terms of just coping.

Their story isn't unique. I mean, there are hundreds and thousands of stories like this in Michigan of head injuries, any number of situations where people have had accidents and, of course, all kinds of profiles can come from that. But the idea that we are not going to reclaim our people, to me, is just an alien idea.

When you are in war and somebody gets wounded, you don't leave the person out on the battlefield. You make every effort you can to go and get the person, bring them in and patch them up so that they can go on and have their lives. You don't abandon people who are in trouble, although our society has gotten away from that.

If you look at the decade of the eighties, there has been an awful lot of selfishness and heartlessness, I think, in terms of some of the things, the priorities, some of the cuts in the government budget. A lot of other things have tended to have us walk away from these problems. They could be our problems. I always think that we should have a human value anyway, that we should care about each other. But quite apart from that, a country has an obligation to its people.

In other words, the real reason you have a country is that you unite for some common purposes, one of which is to look after each other. The whole reason we have a defense budget is not just to keep from getting shot ourselves, but to make sure that the guy across town doesn't get shot or some other State doesn't get shot or some other town. You want to have a common defense; you want to have a strategy that is sort of one for all and all for one; you want a system in which we look after each other.

Of course, if we do that, it is not only the right way to live, at least according to my way of looking at human values, but it is a smart way to live. It is an efficient way to live. There is all kinds of economic benefits in that. If we help each other through the hard times, we are stronger as a group. We have got a stronger country. We set the right example for our children in terms of how they view other people and relationships and so forth. So there is every good reason to not walk away from the people who need our help.

One of the troubling things about the insurance system, is that once somebody really gets a serious problem, by and large, the insurance system wants to say, "Okay, I don't want anything more to do with that person." At the very time they desperately need the insurance, the system says, "Well, let's get rid of that guy or that woman, because they're going to cost too much," and that is the time when you want the insurance system to be there.

If there is ever a time when you need it, it is when you really need it. So that is what it should be geared to, to meet that problem, not walk away from it. So that is one of the problems that we are facing now in terms of this discussion on universal health care, because what happens is that very often, the person who really needs the help can't get it at any price. Even if you had a lot of money, there are certain people that are considered to be uninsurable because their problems are so severe, and yet, by any reasonable definition of fairness and decency, that ought to be the person we ought to make sure is going to be covered.

Mr. MALLEY. Exactly.

Senator RIEGLE. That is why these hearings are important on a lot of levels. It would be good if we could have this kind of a discussion that the whole population could be part of, because I think most people deep down inside feel that way. But sometimes we lose our way. We get distracted by other things. I mean, we have had sort of have a Rolex watch mentality the last decade, and an awful lot of people think you should get a Rolex watch or a certain kind of a car or this or that. There is a place for material things in our lives, but they should not dominate.

Mr. MALLEY. If I could say just one thing more, Senator, about the automobile no-fault law that we have in Michigan, presently, it costs every automobile insurance policy holder approximately $60 a year for the automobile no-fault system, and the auto no-fault system guarantees that a person will receive the proper care that they are required due too catastrophic injuries from an automobile accident: spinal cord injury, amputation, head injury, whatever.

Senator RIEGLE. Right.

Mr. MALLEY. I think that it demonstrates well what you were talking about: ourselves as a society taking care of ourselves, For $60 annually, I can guarantee that citizens in Michigan will have that type of coverage, and what concerns me is a discussing of wanting to change that law so that we won't have it any longer.

I think citizens need to be educated about what it is that we have.

Senator **Riegle**. You make a good point, and I appreciate your coming forward to do so. We have got one more person that has indicated a desire to speak, and it will be our wrap up speaker, and that is Marvin Kerr. Marvin, do you want to come on up?

STATEMENT OF MARVIN KERR

Mr. **Kerr**. My name is Marvin Kerr.

I would like to apologize for my appearance.

Senator **Riegle**. You look great to me.

Mr. **Kerr**. By the time I got the car dug out I didn't have enough time to change clothes before I came here. In listening to the discussion, I remember during my wife's——

Senator **Riegle**. Just take your time. I know it is hard to talk about these things.

Mr. **Kerr**. During my wife's final obstacle, she had her problems she suffered from for many years, one of which was asthma. She had been hospitalized for it, and it deteriorated to acute emphysema. The doctors and hospital facilities in Algonac did not have adequate facilities to care for her and recommended that she be transferred to a respiratory specialty hospital in Denver, Colorado.

The hospital administrator was expert. He worked with me in every way he could. The only way she could be transferred was by ambulance aircraft. The aircraft company wanted $9,000 to put an aircraft on the line to take her out there. As retired military, I contacted the Ethan Air Force Base, who has three medical flights weekly going out, going to various parts of the country. They offered to take her if I could get her to Woodsmith, which required approximately 50 miles by ambulance, then they wanted to extend that for 24 hours while they evaluated her condition before they transferred her.

Senator **Riegle**. Just take your time. I know it is hard to think about and hard to talk about.

Mr. **Kerr**. Before I could have her transported to Woodsmith, she passed away. If something can be done to get these money-hungry people off their tails to realize we need coverage, it is not $9,000; that people need help.

Thank you, Senator.

Senator **Riegle**. Thank you.

As everybody knows, it takes a terrific amount of courage to step up and talk about a situation that is so personal and so difficult to think about, and yet it is so important we hear about these things. How else are we going to know about them if these stories aren't told and if they are not made part of the record, and if we don't build a foundation for forcing some change to take place?

I appreciate your coming down today and being here and sharing that with us. I am very sorry about the facts. Yes?

Ms. **Koman**. May I speak? I wasn't going to.

Senator **Riegle**. Sure.

Ms. **Koman**. I think I would like to.

Senator **Riegle**. Please do. That is one thing about this government: It belongs to us, so that is why we are here.

STATEMENT OF JO ANN KOMAN, ROSEVILLE, MI

Ms. **Koman**. Thank you. My name is Joe Ann Koman, K-o-m-a-n I live in Roseville. I work in Detroit at a place called Heartline, Incorporated. It is for women who are coming back out from being incarcerated to get back in the mainstream of life. But I think it is a Godsend that I am here this morning and I have heard all this testimony, because I can go from Cheryl's story down to the gentleman who worked with the locals, the union.

I have a daughter. Ten years ago she had rheumatoid arthritis, and we went for help or tried to get help. One of the things that we tried to do was go to the Social Security Board to get assistance, and we were told by the doctor that there was nothing wrong with her, and about 6 months later she had to have both of her hips replaced.

She is 27 today. She has got a small job. She needs to have more surgery, but right now, because of my husband having had a heart attack and in and out of the hospital and because of the fact that he is 68-some years old, he may not have a job coming in a short while. They were talking about cutting back on insurance benefits and that he would have to pick them up. She is not able to be covered under ours, and she does have her own insurance, but it doesn't cover her.

It is just a shame, like you said, that in our country, we are not caring about our people, and we look around at all these other countries that are doing for their people. Where is this number one United States of America? What are we doing?

With all the monies that we have available in this country and all the good things we have, I can't see why we can't really make some progress in helping all people. Thank you.

Senator **Riegle**. You make a very powerful Statement. I appreciate your coming up to do it. You know, you really hit the nail on the head in saying it the way you did, We have got too much trickle-down thinking. We are a very wealthy country, but if all the wealth is sort of at the top, and I don't make this as a class argument, but if that is the pattern we see and whether some trickles down to one person or another who has got a real problem, I don't think, is the way it should work.

Other countries aren't doing it that way. Other countries are paying attention to the needs of their people. Everybody is seen as being important. What has happened in our society is that we seem to have somehow gotten off the track where we view a lot of people today as not being very important. I saw a thing in the paper this morning about homeless people living in cardboard boxes all over the place; I mean, every spot in the country. In Washington, we have these hot air grates on the sidewalks between the government buildings where they pipe the heat around from central power plants. We have people lined up to get on the hot air crates in the wintertime. We have got more people trying to keep from freezing to death in Washington right now than we have hot air grates. We have run out of hot air grates for all of the homeless people, and yet, somehow, there is a disconnect.

It is becoming a more visible problem, but generally speaking, we are not doing very much about it as a nation. We have sort of made the decision that this is an expendable group just the same way we are doing with health care; that somehow or another, we have drifted into a decision or we have, through apathy of selfishness or lack of attention, we have gotten ourselves into a situation where there are an awful lot of problems we are not paying attention to. They are human problems, and they carry with them an enormous suffering and heartache and pain.

Beyond even description, I thank the gentleman that just spoke here and your own comments about your daughter and the uncertainties about your husband's situation. But this gentleman that just spoke, my hat is off to him for coming to do that. Here is a fellow who sounds like he was a career military man, and the terrible heartache that he has had to experience to see his wife die because she couldn't get the help she needed.

This doesn't have to be imposed upon our people. We are at a point now in terms of our economic strength where we can help our people if we want to. If we want to do it, it can be done. I think it is time that we should want to do so and not for just a few, but for everybody. We don't have to know who they are or where they live or what color they are or what their religion is. It shouldn't matter one iota. If somebody that is in this country is in that kind of a situation, they ought to be helped to get back on their feet.

Thank you all very much for coming today. It has been a very good hearing.

[Applause.]

Senator RIEGLE. I really appreciate everybody's presence and participation.

[Applause.]

Senator RIEGLE. The committee stands in recess.

[Whereupon, at 2:18 p.m., the hearing was concluded.]

HEALTH CARE FOR THE UNINSURED

WEDNESDAY, APRIL 18, 1990

U.S. Senate,
Subcommittee on Health for Families
and the Uninsured,
Committee on Finance,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:05 p.m., in Room SD-215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senators Bentsen, Rockefeller, Chafee, Durenberger, and Kennedy.

[The press release announcing the hearing follows:]

[Press Release No. H-25, Apr. 9, 1990]

Finance Subcommittee to Hold Hearing on Health Insurance and Health Care Problems

Washington, DC—Senator Donald W. Riegle, Jr., (D., Michigan), Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, announced Monday that the Subcommittee will hold a hearing on access to health care and the containment of rising health care costs.

The hearing will be held on *Wednesday, April, 18, 1990 at 2 p.m.* in Room SD-215 of the Dirksen Senate Office Building.

Senator Riegle said, "I am holding this hearing on the inter-related problems of 37 million Americans with no health insurance and the rising costs of health care in this country."

"The U.S. spends more per capita on health care than any other nation. We spend more than $660 billion annually. Yet our current system of private and public programs leaves huge gaps in coverage that indicates a serious maldistribution of resources," Riegle said.

"High costs have forced families to absorb higher out-of-pocket costs and have led many to question whether we are getting appropriate value for our investment," Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator **Riegle**. The committee will come to order.

Let me welcome all of those in the committee room. I know there is great interest in our hearing today.

We have some very distinguished witnesses. I will hold off introducing our two very distinguished Governors who are with us today, until just a little bit later. I am going to make an initial comment, and then I will call on my colleagues to do likewise.

I might say, the other day the Labor and Human Resources Committee held a hearing on the health issue and was kind enough to extend an invitation to members of this committee to attend and to testify. Senator Rockefeller and I were able to attend. We are very pleased to have the Chairman of the Labor and Human Resources Committee here with us today, Senator Kennedy, who has been a leader on the health care issue for well over a decade. So, we are very pleased to have him be part of our hearing today, as well.

More than ever before, I think it is clear that our country needs a national strategy for dealing with our health care system. Our health care system, the most advanced and sophisticated in the world, has nevertheless failed in two important ways:

As we know, tens of millions of Americans are without health insurance or the financial resources to purchase health care services which they and their families, of course, need. In addition, our health care system is the most expensive and in many ways the most inefficient in the world.

A more efficient, better-designed health care delivery system could provide care to all Americans without utilizing additional national resources. So, access to health care and the cost of that health care are the issues that we will be looking at here today.

Every day we read and hear about these issues. Earlier this month it was reported, for example, that 65 community hospitals closed last year. In my own home State of Michigan there are some 20 hospitals that are expected to close over the next five years.

Throughout the country we see this pattern, where hospitals are being forced to close for a variety of reasons, but a major reason is inadequate payments for services. Hospitals alone in this country are spending over $8 billion a year in uncompensated care costs. Clearly, that problem must be solved.

A new Census Bureau study reported last week that even more Americans, 63 million of them, lacked health insurance protection when the number of individuals with interrupted private or public coverage is considered. In Michigan, our subcommittee heard testimony that people are in fact dying and have died, because they did not have access to health care.

The hearing today is part of an ongoing effort by the Bipartisan Senate Working Group on Universal Access to provide health care for all Americans. The Senate Working Group has compiled a document of options that this group has been considering.

On a bipartisan basis, this group plans to develop legislation that is self-financed. In developing our proposal, we intend to draw on the data and recommendations of individuals and organizations having an interest in health care issues. The document includes, among its options, the recommendations of the Pepper Commission.

Senator Rockefeller, as we know, has done a tremendous job, put in great time and effort on this issue, and has been a central member of our working group. I mention, as well, the participation of Senator Kennedy and his leadership on his committee.

We are making an important incremental first step. Tomorrow I will be introducing legislation with Senators Bentsen and Chafee and many others on the Finance committee that expands and improves Medicaid for low- income children. It is a national disgrace that one out of five American children has no health insurance whatsoever.

Today we will hear testimony from several different perspectives about ways to control rising health care costs in this country and the need for a solution to the problems of millions of Americans who have no health insurance. Clearly these two problems are interrelated, and they have to be solved at the same time. It is certainly my intention and I think that of the Working Group to deal with both problems simultaneously.

So, with the key experts on health policy in the Senate, together with the help of individuals, organizations, and outside experts like those we will hear from today, led by our two Governors, who have shown great leadership on the health issues, we can and must accomplish the goal of universal access to affordable and high-quality health care in this country.

With that, let me now call on Senator Chafee for opening comments.

OPENING STATEMENT OF HON. JOHN C. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator **Chafee**. Thank you, Mr. Chairman. I believe I will reserve the introduction to the Governor until we finish the opening Statements.

Senator **Riegle**. Very good.

Senator **Chafee**. First of all, I want to thank you, Mr. Chairman, for holding this hearing today. I believe that, easily, the most important domestic challenge facing our country in this last decade of the century is how to provide proper health care for our citizens and how to pay for it.

American health care is clearly admired throughout the world. We can save the life of an infant born months prematurely, weighing barely a pound, and yet we still have the highest infant mortality rate amongst any industrialized nation in the world. We can sustain the life of a man with an artificial heart until a transplant organ becomes available and then add years to his life, but American children still die of measles.

I have been working closely with you, as you mentioned, Mr. Chairman, in an effort to address the increasing number of individuals who have limited access to health care which so many Americans take for granted.

In July, as you mentioned, we formed a Working Group to better define the gaps in our system and to identify their cause.

Now, the frustration about the cost of our system is clearly being felt throughout the nation, by corporations, individuals, employees, health care providers, and governments.

Everybody is complaining about the cost of the system, and well they should: we spend $660 billion a year—even for somebody from Washington, that is a lot of money—and that is nearly $2 billion a day on health care for a system that serves too many of us inadequately and poorly. That is the most expensive per- capita health care system of any country in the world.

We spend a greater percentage of our gross national product on health care than any other nation, and yet we lag behind the other countries on key end issues. Whether it is infant mortality, or life expectancy, we are just not cutting the mustard.

And we drift from one crisis to another, scraping together just enough money for what is needed at the time, enough to get us by the immediate problem.

For a long-term solution, I think we have to have a two-track approach:

First, I think we have got to work toward restructuring our whole system, reordering our priorities, and devising a way to deliver appropriate health care to Americans.

At the same time, I think we ought to look at malpractice relief, incentives for employees and employers, managed care, cost-sharing, and perhaps insurance market reform. All of these things we ought to look at, while proceeding at the same time with some fixups to the system.

As you mentioned, your legislation that I am joining you on is to provide better coverage for children through the Medicaid system.

So, Mr. Chairman, we have a big challenge in front of us, and certainly we ought to be able to do more with $660 billion than we currently are.

So I commend you for convening these hearings today, and I look forward to these and the follow-up hearings.

Thank you.

Senator RIEGLE. Thank you very much.

I want to stress again that we are determined not only to do the job but to do it on a bipartisan basis which has been the long history of the Finance Committee. It is the way the country ought to solve this problem; that is, joining hands to figure out how we get it done and not just talk about it.

Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I also think it is incredibly important, this kind of relationship between Senator Kennedy's Labor and Human Resources and the Finance Committee, and your own subcommittee, which you chair.

When you get a situation where the Census people, come and say, "We now have 63 million uninsured Americans," when we have been dealing with 31 million, it is an obscenity.

We thought we had 8 million uninsured children in terms of health insurance. Proportionately, that means we have closer to 18 million uninsured children now, if the census count is correct.

So, the question of access and the question of cost containment? I remember, at the beginning of the Pepper Commission, we had a big argument: Should we do cost-containment first? Some people wanted to do that—"Let's do cost containment, and get cost-containment nailed down into a perfect world, where everybody is behaving exactly as they should, and then we will start doing access." That was rejected, on the basis that you can't hold people and children hostage to an incredibly complex system, which very few people in the Congress or in the country understand.

Senator Chafee mentioned the $660 billion that we are spending on health care in this country. The Pepper Commission estimates that by the year 2000, which is less than 10 years away, it is going to be a trillion and a half—a trillion and a half dollars. The only thing which is growing faster than the cost of health care is the number of uninsured people.

So, here we have a hearing which is meant to look at access and cost containment. I welcome it, but I have to say there is a lot of variety in how people approach cost containment. Some want a free market approach, some say it ought to be regulatory, some want to start all over again and figure out the entirely perfect system. All I know is that, with this many people uninsured, with the cost of health care where it is, we have got to start something very fast in this country.

We are not going to be able to arrive at the perfect solution; we have got to arrive at a solution that will work, that will bring into a consensus the broad mainstream of players, and we can get legislation through the Congress which provides access to every single American, which every other industrialized country has, other than South Africa, and we have got to do it very quickly.

This is a problem which has exploded on us. It has been happening for a long time, but, except for people like Senator Kennedy and others, nobody has been noticing. Well, darn it, now we have got the chance to act. We have the crisis to act.

People say we don't have the money to act; I think that depends on how much we care about people being uninsured. I think we care a lot, and I think saying we don't have the money is unacceptable in today's climate.

Senator RIEGLE. Thank you, Senator Rockefeller.

Senator Durenberger?

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Thank you very much, Mr. Chairman.

I have a full Statement that I would like to be made part of the record.

Senator RIEGLE. We will make it part of the record.

Senator DURENBERGER. Just some brief comments:

First, thank you and thank all of the members of the Joint Working Group. I am pleased to see both my Chairmen here today—the Chairman of the Finance Committee and the Chairman of the Labor and Human Resources Committee, from whom I have learned a great deal about this subject—to see the two Governors from New England here, particularly the Governor of Massachusetts, who did have the nerve to make this an issue in the last election. I compliment him for that, for trying, and I think it is an issue that folks here know deserves that kind of debate, and I hope by 1992 we will see it as one of "the" principal issues in our debate.

I applaud the work that this group has done and that my colleague from West Virginia and I and others tried to do on the Pepper Commission report. I say "tried," because for a while at least I think we tried to come up with a solution to the problem.

What we have done, as the result of the Pepper Commission, is given legitimacy to the debate that I said earlier the Governor tried to start in 1988 and wasn't necessarily successful at. But there is now a legitimacy to our debating this issue in a national forum like this and a variety of other national flora.

I happen to have disagreed with my chairman of that committee on the best way to approach the solution to universal access. I hope, during the course of the testimony today from some of the most excellent witnesses that I think we could gather for this purpose, that we will debate principally the role of the work place, as the place that we want to in effect extend the requirements of providing for certain services that are outside the mandate of work.

Are we going to require that health care for moms and kids and families, and so forth, be covered at work in the same way that we have workers compensation requirements, or not?

I hope that during the course of the discussion today we will talk about the capacity of the work place of the next decade in America to handle this challenge, with the variety that has been introduced into the work place.

I hope, in particular, we will hear about the health insurance industry, which to me is a fairly weak reed on which—if I were an employer of a lot of people, or if I were a State like Massachusetts—on which to rely to finance access into this system.

If there is a part of the problem in financing access that the Pepper Commission discovered, I think it is currently the way we use health insurance to finance access into the system, that part of the exaggerated costs in the system are due to the way in which we have used that particular system.

Finally, I think, particularly from our Governors and I am sure from those who represent national business organizations, I would be interested in knowing the most appropriate role of the States in fulfilling this obligation.

There are some of us who might say that the Pepper Commission recommendation for "pay or play" was stopping off in Massachusetts on the way to Canada, and that the real secret agenda for some people is to go to a Canadian system, where the provincial government or the national government in some way or another is the only place in which we can make decisions about access, and so forth.

I, as others here, will certainly be interested in the observations that the Governors will make on the necessity for a State like Massachusetts, or any State, to have to deal with regulating hospital prices, doctor prices, as a way to make this whole system affordable. And if that is a necessity, I wonder whether or not we aren't on our way to Canada, and how comfortable the rest of the witnesses here, particularly those representing business and unions, are going to feel about moving the United States to Canada on a system which is as personal and important as this one is to all Americans.

Senator RIEGLE. Thank you very much.

Now, our distinguished Chairman of the full Committee, Senator Bentsen.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. Thank you very much, Mr. Chairman.

I have some testimony that I will give, in its entirety, to be put into the record.

Let me congratulate you on this meeting and the quality of the witnesses that you have been able to bring to it. I am delighted to see my good friend, the distinguished Governor of Massachusetts, who has shown a great deal of vision, courage, and commitment on this particular issue.

Finding an affordable way to provide health care to 63 million Americans is a tough one, and it is one that is going to be expensive for both the public and the private sector. That is one of the reasons I think we have to take an incremental approach in trying to bring it about.

Part of that we are doing with what we are introducing tomorrow. So many of us on the Finance Committee have joined in that one, in bringing affordable health care to the children of this country, up to the age of 19, with family incomes up to 100 percent of the Federal poverty line.

In doing that, we have done a great deal of consultation with the Governors across our country, to see that we do it in a way that they can meet that kind of challenge and bring it to a successful culmination.

I would like to extend the rest of my remarks for the record.

Senator Riegle. Thank you, Senator Bentsen; we will make them all a part of the record.

Now we are pleased to also be joined by Senator Kennedy.

Senator Kennedy, would you like to add a comment here?

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM MASSACHUSETTS

Senator Kennedy. Thank you, Mr. Chairman.

I want to, first of all, express my appreciation to you, Senator Bentsen, and other members of the committee, for the courtesy of permitting me to join with you and attend these meetings. I reiterate, speaking for the members of our Human Resource Committee, our strong desire to work closely with the members of this committee. We want to work very closely.

We understand that part of the reason we are facing this national challenge today, I think, is because, in the past, too often we didn't work in a coordinated way.

We need to leverage the health care system through financing so that we can get more effective delivery, and we need to work together to be successful.

Let me ask that my full Statement be put in the record and make one final comment, because I think the facts have been outlined very well.

Just two brief observations:

First, even if you have health insurance today, you may have just one job loss, or job change, or serious illness, or employer decision away from losing it. So, the uninsured and the currently insured need protection.

Senator Rockefeller outlined what the current problem is in terms of the numbers that don't have it; but, even if you have got it and you lose your job, by and large it is gone.

Second, Mr. Chairman, is the overburdening, today, as we meet, on the health care system. You can have the greatest health insurance in the world, and if you have an emergency, in many areas of this country, you may wait up to 7 days in an emergency room to get treatment. So it is not just the issue of those that are uninsured; we have a system which is in crisis and crumbling.

The final point that I would make, before just mentioning a word about the Governor, is that we have had three important national studies. I would hope, with the leadership of Chairman Bentsen, Senator Riegle, Senator Rockefeller, Senator Chafee, and Senator Durenberger, that we could get about the nation's business on this issue.

This issue has been studied and studied and studied, and I believe it is time we take some action. The American people need it. Every day they have the enormous human tragedies, which all of us are very familiar with and we have all seen, so there is an important responsibility, I think, as legislators to develop the kind of public/private partnership which can and should be achieved.

Our Governor has been a leading light in this whole debate, not only in the course of a national campaign but in speaking all over the country about it. I am proud he is our Governor, and I am enormously proud of the extraordinary leadership he has provided and his own strong personal commitment on this issue in our State. He has spent a great deal of personal time on this problem and I know not only the citizens of Massachusetts benefit from it but I believe people across the country benefit from the kind of debate, discussion, and consideration that has been given to this issue in that State.

I thank you very much, Mr. Chairman.

[The prepared Statement of Senator Kennedy appears in the appendix.]

Senator RIEGLE. Thank you, Senator Kennedy.

Let me now invite our two Governors to come to the witness table, Governor Dukakis and Governor DiPrete.

We are delighted to have both of you. I know you leave very busy schedules to come today and help us understand this problem through the vantage point of the State perspective.

I will just add a couple of words of introduction with respect to Governor Dukakis. Then I will call upon Senator Chafee to introduce his Governor.

I might say that Senator Pell was here earlier, to welcome you. He wanted to extend his greeting to you.

I know, Governor Dukakis, that in Massachusetts some extraordinary initiatives have been taken to provide health care services. I think you can offer a lot to us with respect to the cross-relationship between access, on the one hand, and cost-containment, on the other.

So, we are delighted to have you with us today. We are very pleased to have your testimony, after your fellow Governor is introduced.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Edward DiPrete has a long-time career in public service and an effective career. He served on his school committee in his city and was later chairman of it; he served as mayor of his city for 6 years, and now he is in his sixth year as Governor of our State, having been elected three times.

Under his leadership we have adopted many innovative health programs—Right Start, a program which provides maternity care coverage to low-income women who are ineligible for other medical assistance; pharmaceutical assistance for the elderly, under which over 16,000 Rhode Islanders are covered for expensive prescription drugs; and fighting cancer through the establishment of a nationally- recognized breast cancer screening program, with the goal of reducing deaths from breast cancer by 30 percent.

So, he has provided excellent leadership in the health care field, and it is a great pleasure to have him with us today, Mr. Chairman. I introduce him and welcome him to this committee

Senator **Riegle**. Very good. We are delighted to have both of you with us.

Governor Dukakis, I know you have given us a prepared Statement, but why don't you give us your summary comments and observations. We would be delighted to hear from you now.

STATEMENT OF HON. MICHAEL S. DUKAKIS, GOVERNOR, STATE OF MASSACHUSETTS

Governor **Dukakis**. Mr. Chairman, thank you very much. Senator Kennedy, all of the members of the committee, Senator Durenberger. Thanks for those kind words.

Senator Bentsen and I had lunch together and then strolled over here together. It was a little quieter than the last time we made that stroll; but we didn't engage in too many "what might have beens," we were talking about what is ahead. It is just a great pleasure to be with him, an old gubernatorial colleague from West Virginia, a near neighbor from Rhode Island, as well as Governor DiPrete, who is a friend and a colleague.

Let me give you my fairly brief prepared Statement. I have also brought two of my best, Phil Johnston, my Secretary of Human Services, and Jim Hooley, who is the Commissioner of the new Department of Medical Security and probably knows more, Mr. Chairman, about how you put a universal health care program into effect than anybody in the United States of America. So, they are here in case I falter or you have additional questions that I can't answer.

As all of you have said in one form or another, we are now spending almost $2 billion a day on health care in this country. Millions of Americans have no health insurance, and millions more are underinsured, and that number grows every day as hard-pressed businesses try to deal with the cost of health care. We are spending more on health care than any other nation in the world, and yet millions of our fellow citizens go to bed at night not knowing whether or not they are going to be able to pay the bills if their kids get sick.

During the presidential campaign I often spoke about my dad, who practiced medicine for 52 years and was a family doctor in a simpler time when a doctor's first question to a patient was "Where does it hurt?" and not "How will you pay?" Today, far too many Americans, most of them members of working families, live in fear of the first question because they can't answer the second.

Mr. Chairman, I believe as strongly as I believe in anything that basic health security should be the right of every American. And I am proud to say that in my own State we are committed to providing basic and affordable health care for all of our citizens.

We had some rocky beginnings, as all of you know; but I am happy to report to you today that we are on track and on schedule. In fact, by the end of this year we will be covering over 100,000 previously uninsured or uninsurable citizens.

The first phase of our Health Security Act is what we call the "CommonHealth" program, which is paid for principally with State dollars. It is designed for three categories of people: disabled adults who are working—and, by the way, we have a substantial and growing number of people who are now leaving SSI Disability and moving back into the work force, because they no longer live in fear that by doing so they will lose their health benefits—severely disabled children, many of whom simply are not insurable under existing insurance arrangements, and welfare recipients who leave the welfare rolls for jobs that do not provide health insurance. More than 17,000 persons have been served by CommonHealth since we began that part of our universal health care plan.

In May of 1989 we began what we call The CenterCare Program, another important aspect of our plan which provides primary health care services to inner-city residents through participating community health centers. More than 5,000 individuals now have access to those services.

Last September we required all full-time college students and graduate students—and we have 400,000 of them in my State—to demonstrate either that they have health insurance through their parents or guardians or else purchase a plan from the institution they attend. We discovered that about 50,000 of those students—including, by the way, graduate students with families—had no coverage of any kind.

We worked with college administrators and insurers to help develop affordable basic health insurance packages for these students.

And we were able to develop a variety of plans at an average cost of less than $300 per policy. In fact, there are some graduate students in Massachusetts right now who have the best health insurance bargain around.

This summer we will begin the next major phase of the Universal Health Care Law: All Massachusetts employers with more than five employees will pay $16.80 per year, per employee, to create a fund which will provide health insurance for uninsured unemployed workers, the very people that Senator Kennedy was talking about. We estimate that at any one time in our State some 30,000 unemployed workers and their families will be covered by that plan.

Finally, we are now in the process of phasing in a series of pilot programs that we hope will provide small businesses with affordable health insurance for their employees.

Eighty-five percent of our small businesses already provide health insurance to their workers, and most of the rest want to. This is not a question of employers who don't want to do this; most employers I know want to do it, think it is the right thing to do, think it is important, to attract the best employees. The problem is that they can't if they have to pay a premium on top of a premium, and that is what is happening.

Last week I visited a small business that is taking advantage of one of our phase-in programs, one that is being marketed by the John Hancock Mutual Life Insurance Company.

Chris Anslono, the young owner of the Lynn, Massachusetts, Carburetor and Auto Service, has three employees in addition to himself, and he had just about given up hope that he would ever be able to afford health insurance for them or for himself. Now, under the phase-in, working with John Hancock, he will be able to provide his family and the families of his employees with basic health insurance.

By 1992 we hope that all of our employers with six or more employees will be able to meet the law's mandate at a price that they can afford, because beginning in that year all such businesses must provide at least $1680 worth of health insurance to each of its employees. If they don't, then they must contribute that much to a special State trust fund, and the Commonwealth will provide the insurance.

So, after 2 years, Mr. Chairman, I believe that our State's experience provides some important lessons for any national health plan.

First, we believe it makes sense to use the present employer-based system as the foundation for any national plan. It is the simplest, the fairest, and probably the most equitable way to extend coverage to workers and to their families.

Second, we have found, not surprisingly, that the uninsured are not a homogeneous group; they are young and old, working and unemployed, students, disabled working adults and children. And as we have discovered, we will need a variety of approaches.

Third, we need reforms in our insurance system that will prohibit the denial of coverage because of a previous condition and will prohibit the charging of higher rates to small businesses, a very serious and growing problem, as I think all of you know.

I am proud of the progress we have made in Massachusetts, but we are not alone; an increasing number of Governors, frustrated by the lack of action here in Washington, are moving ahead on their own. The States of Washington, Hawaii, California, New York, Ohio, and Michigan are among those who have acted to ensure basic health care coverage to their citizens or have comprehensive proposals under consideration.

But as much as we at the State level relish our role as national laboratories, 50 health care experiments won't give us the kind of national guarantees that our citizens deserve.

Moreover, we at the State level, as I am sure you recognize, have a huge stake in finding ways to bring health care costs under control. Without some reasonable control over costs, we will never achieve the goal of basic health security that President Harry Truman proudly proclaimed in 1949.

I think I can say to you, without fear of contradiction, that the exploding costs of Medicaid are causing every State in this country very serious budgetary problems. I know that Governor DiPrete and I, and dozens and dozens of Governors, can testify to that.

Booth Gardner, the Governor of Washington, who will assume the chairmanship of the NGA this summer, has already made it clear that health care will be the top issue during his tenure. A health care subcommittee of the NGA has already been formed to look at the twin issues of health care access and cost containment.

A number of us who have been asked to be members of that committee hope that on the eighth of May we can meet with many of you in a health policy discussion roundtable that we hope would run at least a couple of hours, Mr.Chairman, and include Members of the House, so that we can share some ideas informally as well as in formal settings like this one.

It is my hope that under Governor Gardner's leadership the nation's Governors can work with Congress and the Administration to make this the year that puts us on the road to universal health care. We did it on welfare reform in 1988, and I believe we can do it again.

Thank you very much for inviting me, and I look forward to responding to your questions.

[The prepared Statement of Governor Dukakis appears in the appendix.]

Senator RIEGLE. Thank you very much. We appreciate that very pointed summary, and your full Statement as well.

Governor DiPrete, we would like to hear from you, please.

STATEMENT OF HON. EDWARD D. DIPRETE, GOVERNOR, STATE OF RHODE ISLAND

Governor DIPRETE. Thank you very much, Mr. Chairman and Members of the Subcommittee.

As Governor of the State of Rhode Island, certainly I am honored to be here, alongside my colleague Governor Dukakis, today to have this opportunity to testify before the Subcommittee on Health for Families and the Uninsured.

In recent years the health care system across the country has approached a State of financial emergency. In fact, I think Senator Kennedy referred to it as "crisis," and that is even more accurate than "financial emergency."

Rhode Island is no exception. Consumers, employers, health plans, and hospitals have all felt the impact. Health costs continue to rise at an unacceptable rate. And as costs have risen, the number of uninsured Rhode Islanders has continued to grow at an alarming rate, as well.

Here are some problems that we face:

(1) The total cost of health care in Rhode Island has grown from some $2 billion in 1987 to $2.6 billion in 1990. That is an increase of 30 percent in just 3 years.

(2) Many Rhode Island businesses are facing double-digit increases in their health insurance costs. Companies are paying much more in health benefits at a time when the New England economy is experiencing a slowdown.

(3) Some employers are asking workers to pay a higher share of the growing cost of health insurance. Such requests are being vigorously resisted by labor, and tensions between management and

labor are growing. In addition, consumer-advocate groups have called for a freeze on health insurance rates.

(4) The State Government in Rhode Island is paying twice as much for employee health benefits today than we did just five years ago, and the prospects are that these costs will double again over the next 4 years.

(5) One of Rhode Island's three major health plans was granted a 43 percent rate increase this year, and despite that huge increase, 43 percent, the health plan is still in financial difficulty.

(6) The percentage of uninsured in Rhode Island grew from 3 percent in 1975 to 8 percent in 1987. Between 1987 and this year, the rate has actually increased on a proportionate basis by 50 percent; or, in other words, it is now 12 percent.

(7) Almost all of our 15 private hospitals have been struggling financially over the last 3 years. They have had to contend with minimal increases in Medicare payments, double-digit wage increases in what had been a very, very tight labor market, and rising amounts of free care and bad debt. Last year my administration had no choice but to provide $3 million in emergency relief to hospitals. If we had not acted, at least one inner-city hospital would likely have closed its emergency room,which serves 40,000 people a year, and clearly—clearly—we could not take that risk.

Public and private leaders in Rhode Island have been taking numerous steps to stabilize the situation, and some progress has been made. However, it is apparent that States alone cannot adequately address the crisis in health costs. The Federal Government, which is the dominant payor in the health system, needs to take the preeminent leadership role.

In Rhode Island, State Government has used its regulatory powers throughout the Eighties to restrain the growth of hospital expenditures and insurance rates. Last year we provided some cash to the hospitals at their time of greatest need, and this year we are tackling the problem of uninsured medical payments.

The uninsured rate of 12 percent is low compared to the estimated national average of some 17 percent; but the amount of free care and bad debt absorbed by the hospitals has roughly doubled since 1982, and the amount exceeded $30 million a year in 1989. Our inner-city hospitals carry a disproportionate share of the burden.

More than 80 percent of the uninsured in Rhode Island are employed or dependents of working parents, but the employer usually is a very small firm with 25 or fewer employees. The number of uninsured seems to be growing particularly because ever-higher health insurance rates are simply pricing companies out of the insurance market.

An important reason for the premium increases is the growing list of health benefits that the State requires all carriers to offer. Our legislature has mandated—with all good intentions and sometimes, if not frequently, with my support—such benefits as prenatal and pediatric services. Senator Chafee referred to our RIte Start program, which zeros in on low-income people even before the date of birth, to be sure that all possible prenatal care and pediatric service care is available.

Also mandated have been chiropractic services and in-vitro fertilization. However, it is estimated that all mandated benefits add as much as 25 percent to the cost of health care in the State of Rhode Island.

The hospitals have been particularly hard-hit by the growing number of uninsured patients. This is because many physicians and dentists just don't accept the uninsured. As a result, many end up seeking treatment in the high-cost emergency rooms of hospitals around the State.

In response, I have introduced legislation this year that permits insurers to offer a basic insurance package. Carriers will be allowed to market plans with fewer benefits, at less cost, to the uninsured.

Our hope is that this pilot program will succeed in reducing the ranks of the uninsured, while lowering the levels of free care and bad debt that the hospitals must bear.

This legislation was introduced at the recommendation of a steering committee that I had appointed, and the committee is also evaluating the feasibility of a freeze on insurance rates or a provision strictly limiting growth in such rates.

But I think equally, if not more importantly, the committee is studying whether to strengthen the power of attorney law in instances where patients do not wish extraordinary measures to be used to prolong their lives. That, incidentally, happens to be very consistent with my own personal philosophy, and I have previously supported and signed such legislation in Rhode Island.

It is encouraging that, whereas total health costs in Rhode Island have risen by 30 percent between 1987 and 1990, hospital costs—have grown by less than 22 percent during the same period. This is concrete evidence that health costs can at least be slowed down.

State Government has played a lead role in curtailing hospital costs, and, briefly, here is how we have controlled at least some of the expenditures:

Each year the State, the insurance industry, and the hospitals agree on a percentage increase in the operating budgets that will be permitted for all hospitals as a group. Individual hospitals then must negotiate any increases that are greater or lesser than the overall cap.

In addition, each hospital must apply for a certificate of need authorizing any major expenditure, and certificates are needed for major new programs that come on to the operating budget as well as major capital expenditures.

We in Rhode Island are hopeful that the worst is now behind us. However, a single State such as our own can do only so much to consider and to conquer one of the most honest domestic problems that face us in America. States need leadership and direction from the Federal Government, which is the dominant market force because of Medicare and Medicaid.

As you continue with your deliberations, please keep in mind that Rhode Island—a State of about 1 million people, a compact State—has a large and diverse population. It is a perfect setting for pilot programs that can be evaluated for use as national models. We in the State Government are ready and willing to assist the

Federal Government in providing all the desired medical care at an affordable price to all Americans, from wherever they come.

Thank you, Mr. Chairman.

[The prepared Statement of Governor DiPrete appears in the appendix.]

Senator **RIEGLE**. Thank you, as well, for an excellent Statement.

Let me say to both of you: You are both Governors from different political parties. In my home State of Michigan, Governor Blanchard has taken the lead with a program called "Healthy Start." Out in California, our biggest State, Republican Governor Deukmejian has taken a lead out there with his legislature to move against this problem. But as Governor Dukakis cited earlier, the number of States that have responded, it is a very small fraction of the 50.

Some people might say, "Well, the States are now moving. The States, even if it is in response to an emergency or a crisis, are doing the job, and let us leave it to the States; let us have the 50 different experiments and arrangements, and so forth. Even if it takes a long time, you know, let us solve the national problem that way."

I don't subscribe to that view, but I think it is important that we hear from Governors who are actually in the driver's seat in terms of having to face these problems—different States, different parties—as to what is or is not workable.

You have both testified today that we need to look at this and respond to it in national terms. I would like you to explain why. Why can't the States on their own, with their best efforts, get this job done sufficiently? Why does this require a national strategy?

Governor **DUKAKIS**. Mr. Chairman, I think all of you in your opening Statements answered that question. If the number of people uninsured or underinsured is rising in this country, and it is—my State is one of the few exceptions to that—if costs are going out of sight, if employers, who are the principal payors in this country, are finding it virtually impossible to continue to insure their employees, then despite noble efforts at the State level—from State to State, from Governor to Governor—as a nation we are not doing the job. That is why you are here, and that is why we are here.

Not only are we one of the few industrialized nations in the world not to provide basic health security for our citizens, the situation is getting worse, not better, despite our efforts.

Let me also say to you that we have two other problems, related to costs, with which you are familiar. One is the exploding cost of Medicaid; the other is cuts here in the nation's capital on Medicare.

Roughly fifty percent of hospital revenues in this country come from Medicare. Every time you folks cut Medicare, the hospitals go some place—they are going to State governments, and they are going to employers. That is why premiums are rising so much faster than actual increases in health costs, because of this massive cost shifting that is taking place.

As a matter of fact, I have a hospital on Cape Cod, the Cape Cod Hospital, 70 percent of whose revenues come from Medicare, because there are many retirees and because the population in that particular area is so much older than the average population in other parts of the State and other parts of the county.

So, you put all of these together, Mr. Chairman, and there is no way, by ourselves, that we can do this.

Now, my State is working hard, and I think so far successfully, to try to demonstrate that it is possible to do this at the State level; but we are fortunate, in some respects: We began with what was probably the lowest percentage of uninsureds of virtually any other State in the country with the possible exception of Hawaii. We had a very tight labor market, as Governor DiPrete pointed out, so you had a lot of competition for employees, and more and more employers understood that they had to offer health insurance to attract employees. So, for a number of reasons, we were able to move forward.

But I think it will be virtually impossible for States with 20-30-40 percent of their populations uninsured—and many of the States fall into that category—to even begin to approach this. They have their hands full just trying to keep up with the cost of Medicaid. So if you put all of that together, there is just no way.

Let me just say one other thing, as a matter of decency in national policy: I don't think it ought to make a difference, when you cross a State line, that you can or can't get your kids health care. I mean, this is one country. We are the most affluent nation on the face of the earth. We are all looking for that peace dividend; we hope one of these days it is going to appear. And for it to make a difference whether you live in Massachusetts, Michigan, Montana, or Mississippi as to whether or not you can provide health care for your family seems to me to be a terrible confession of error.

So, for all of those reasons I think we have got to move together. However, and I know I speak for all of the Governors, we want to do so with you. We think the States have a major role to play—we do, and we should. That is one of the reasons I mentioned welfare reform. I think that was a wonderful example of the Governors and the Congress moving forward together, and I think it is our hope that we can do the same in connection with health care.

Senator RIEGLE. Very good.

Governor DiPrete?

Governor DIPRETE. Mr. Chairman, when Rhode Island passed our RIte Start bill some roughly 3 years or so ago, this clearly passed along party lines. Party lines had absolutely nothing to do with it; it received widespread support in the Legislature and the Executive Branch of Government.

The program aimed at taking care of low-income pregnant mothers from the time they really sought out medical advice right up through all the prenatal care, through birth, and for several years thereafter.

The question was not "Is the State going to pay, or is society going to pay?" I think the question was "Do we pay ahead of time, or pay for perhaps greater medical services or greater diseases down the line?" But even more importantly, I think, is the question of "What is right?" And in this case the decent thing to do was to give the expectant mother the proper prenatal care, regardless of that person's background or income, to ensure the birth of a health baby.

I can tell you of a personal experience in my own family where a pregnant daughter of mine, some six or 7 years ago, who fortunately could afford the necessary prenatal care. In a routine examination the doctor picked up the fact that my grandson Mitchell had two defective kidneys. This never would have been picked up without very close medical supervision. He explained to my daughter that this was a potentially serious condition that was very correctable by surgery, because it had been identified; but the youngster would need surgery within days after birth in order to have one kidney functioning in a healthy manner, and as soon as possible thereafter the second kidney would have to be operated on.

Had she not been under the care of a qualified obstetrician, had just gone her way, and had the obstetrician not noticed in a sonogram that this was a potentially serious condition, the boy would have been born and probably would have been sick a long time before anybody ever realized, "Well, do we have a kidney diagnosis?" Thank God the help was available ahead of time. And the person's background, economic status, social status, or whatever, should have nothing to do with the birth of a healthy baby.

The States could not wait for the Federal Government. Maybe we could argue who should have paid what. But at that time, particularly, States in the Northeastern part of the country had greater resources available for such good programs than we do today. Hence, we moved ahead.

Senator RIEGLE. And I take it, just as my time is up, that your view is also one that, try as they might, the States by themselves can't get this job done? It is your testimony to us that we really need a national strategy here?

Governor DIPRETE. There are too many issues that go across State lines. We need a national strategy for perhaps malpractice coverage, and rates, and terms and conditions, to other terms and conditions of insurance, and a whole host of other issues that don't stop at the State line.

Senator RIEGLE. Thank you.

Mr. Chairman?

The CHAIRMAN. Governor Dukakis, you were speaking about the variants in the States insofar as the coverage of the uninsured. For your own State, was it around 10 percent when you put in your program?

Governor DUKAKIS. That were uninsured?

The CHAIRMAN. Yes.

Governor DUKAKIS. We are at about 8 percent right now, and we hope and expect that number will decline as we move ahead toward universal coverage.

The CHAIRMAN. Yes. But before you started your program was it 8 percent?

Governor DUKAKIS. It was higher. And even at that level we were among the lowest in the country, with the possible exception of Hawaii.

The CHAIRMAN. I know in my own State it is 30 percent, so I can see what a formidable task you had, and I can just imagine what we are faced with in the State of Texas.

I am impressed with the fact that you are doing a number of pilot programs for small business, because we find so many of the marginal small businesses are finding it almost impossible to pay the premiums.

Governor DUKAKIS. Right.

The CHAIRMAN. I see them time and time again in particular dropping dependents and not giving them coverage.

Governor DUKAKIS. Right.

The CHAIRMAN. What do you find is working, and what has been most effective in the way of some of these pilot programs? Have they been under way long enough to get a feel for that?

Governor DUKAKIS. We are just beginning to phase them in, Senator. They do involve some State subsidization, both in a direct way and through some tax incentives. We are working with an interesting variety of insurers and managed care plans and HMOs to test out the approach in various parts of the State.

But cost, obviously, is a factor here, and there is no way of getting around it.

We have also had a series of hearings across the State with the small business community, asking them to participate and give us their input.

What is coming back to us over and over again is that too often small business is individually rated in a way that makes it virtually impossible for them to pay the premium; if, for example, they have got 7 or 8 employees, one of whom has a pre-existing condition or a serious disability. I mean, if you are going to rate them on that basis, as opposed to either changing underwriting practices or pooling these risks in a much broader group, then there is no way under the sun that that small employer can possibly pay the bill, and it is very unfair to that particular employee and his or her family who may have that condition.

In some cases they tell us that they get a reasonable premium until somebody really gets sick, then the next year the premium is jacked up on them.

Now, in fairness to the insurance industry, I know the HIAA recently has said publicly. That we have got to do something about this. My hope is that sometime in the next few months I will be able to submit to my legislature, in cooperation with the insurance industry, a series of proposals for insurance reform that will help to alleviate some of these conditions.

But as long as companies are going to be individually rated, and they are going to be penalized, in effect, for having a particular cost problem within a very, very small group of employees, then we are going to have a very tough time insuring them.

So, we are looking at a number of ways. Obviously, the most effective way will be to try to get them in some way to be part of a broader group so that the risk is spread; but I think we are going to have to deal with some of these underwriting practices.

You know, in fairness to the insurance industry itself, they are taking the losses and obviously we have to be sensitive to that. So I think there is an opportunity here for real cooperation between us and the insurance industry, and we hope we can move ahead on these reforms together.

The CHAIRMAN. As you were fashioning this universal health insurance plan, were there any particular government policies—Federal policies, from our standpoint—that were particularly helpful, or a hindrance, in trying to put it together?

Governor DUKAKIS. I think we have had pretty good cooperation from the Federal Government in seeking waivers and other things. I mean, we obviously have a problem with ERISA, which we have tried to deal with in a variety of ways which we hope pass muster legally. But I think, by and large, we have had good cooperation.

Obviously, to the extent that we can move together with you here in the Congress on issues like insurance reform, that is going to make our job a lot easier.

The CHAIRMAN. Well, we particularly did that in this bill that we are introducing tomorrow, working with you and the other Governors, and we will want to continue to do that.

Governor DiPrete, when you talk about the Federal Government having a major role in this, it should have, and it will have. But we are facing the problem here now, with the Administration talking about cutting Medicare by some $5.2 billion, and as Governor Dukakis was saying earlier, you have some hospitals that depend on 70 percent of their income from Medicare, and today you have over 50 percent of the hospitals losing money on Medicare. In my own State, it is over 70 percent. I had 13 hospitals close last year who just couldn't make it, and a big contributing factor was what we have done on Medicare in cutting back on those benefits. So it is a difficult thing to try to accommodate it.

That is why I am particularly pleased with the demonstration projects you are talking about.

Governor DUKAKIS. Right.

The CHAIRMAN. It will give us some counsel and advice as to what we can better do.

Governor DIPRETE. If I could add a couple of points to that, Senator Bentsen, I think we can all agree that the least expensive place to treat people or care for people, particularly the elderly, is at home. I think this is where they will usually want to stay, and families would want them to stay.

Here again, giving flexibility to States to have funds for home respite care, as opposed to having to transfer the elderly person into a nursing home or a full-service hospital, I feel is right, not only from a humanitarian point of view, and a social point if view, and a family point of view, but a cost-effective point of view.

It is far less expensive, in our opinion, to appropriate funds to allow a sick or frail elderly person to stay at home, with limited funds being necessary to provide some sort of respite care or other homemaker services, than it is to transfer that patient, because of bureaucratic rules or insurance company regulations or whatever, to transfer that patient into a higher cost facility.

Governor DUKAKIS. Mr. Chairman, could I add just one other point?

One other area where I think the States can move ahead on their own—and Governor DiPrete has been one of the leaders in the National Governors Association on the issue of insurance reform—is malpractice reform.

We are cutting malpractice rates for dentists by a third this year in Massachusetts, and next year we will be cutting malpractice rates for doctors by 17 percent.

That didn't happen by accident. It happened because we acted legislatively to reform and tighten laws with respect to liability, contingency fees, what a lawyer can charge, those kinds of things. And we have also done a much better job, I believe, on the discipline and professional responsibility side, working in cooperation with the professional associations and our boards of registration.

So, for the first time in many years now, after what seemed to be endless increases in malpractice rates, we are going to be in a position over the next year or two to dramatically reduce them, and that is one area where we really don't have to wait for you all to act; although, as Governor DiPrete will testify, there are things we can do even in that area that would be extremely helpful in a collaborative way.

Senator RIEGLE. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Governors, what I would like to do is ask you a series of questions, because my time is so short here, and see if you agree that these steps could make progress in attempting to reduce the rate of increases, if not hold steady and hopefully reduce the rates themselves.

Governor DiPrete mentioned living wills. Do you both agree that some progress made there would reduce expenditures in hospitals, during last days of a patient's life?

Governor DIPRETE. Yes, I do. And I also feel it would reflect the informed desires of the patients and their families. Basically what we would be saying is that government would not stand in the way of someone being allowed to die a natural death.

Senator CHAFEE. How readily does the legislature accept legislation on that issue?

Governor DIPRETE. Well, the good news, Senator Chafee, is I think legislatures—I can't speak for all of them around the country, but certainly in our State of Rhode Island—are more receptive to this kind of concept and·proposal and program, if you will, than they were 5-6-7 years ago. In fact, in 1985 or 1986 I signed into law a durable power of attorney.

Senator CHAFEE. Governor Dukakis, the same?

Governor DUKAKIS. May I express a somewhat more conservative view than my Republican colleague here? [Laughter.]

Governor DUKAKIS. Senator, I think this is an issue which has to be handled very, very sensitively and very carefully. Even though I think all of us fundamentally believe that people ought to be able to express their desires in this area and have them respected, the decision that a doctor or a professional in the health care field has to make independently of that, as a matter of ethics, as a matter of basic humanity, is not an easy one.

I have talked with many, many practitioners, as I am sure you have, who are often tortured by this question of professional responsibility and what you do under these circumstances.

Senator CHAFEE. Even though the patient has nominated a guardian who is going to say "yes" or "no?"

Governor DUKAKIS. Yes, because there is an independent responsibility that I think most doctors and nurses and practitioners feel, and it is very difficult.

Now, whether this will save significant amounts of money is a good question. I think it is one of those issues where we have got to work with practitioners as well as with individuals and families, try to respect the right of that individual to make those kinds of decisions, but also recognize that there is a kind of independent professional responsibility that has to be considered.

Senator **Chafee**. Next question: Massive changes in malpractice procedures. You indicated that you have made some progress there, in contingency fees, possibly pain and suffering limitations.

Governor **Dukakis**. It seems to be working.

Senator **Chafee**. I think whatever you have done, it sounds good. Governor DiPrete, do you think that will significantly affect the cost of insurance?

Governor **DiPrete**. Yes, I do, Senator Chafee. In fact, I would broaden the agenda, beyond simple malpractice insurance, to products liability insurance. Certainly some of that finds its way into the health care field, where certain sophisticated machinery may be made in one State, transported to another State, and sold in another State, serviced by people yet from another State.

I chaired a subcommittee of the National Governors Association two or 3 years ago that finally went to the full membership, which approved a reversal of previous NGA policy and specifically asked that Congress enact a Federal products liability statute.

Senator **Chafee**. Next, mandatory helmets for motorcyclists. Most States seem to have succumbed to those who have sought repeal. I guess in our State we had it, and then they repealed it. Obviously, I believe it would greatly reduce the cost of caring for those folks, if they wore helmets. Are you making any progress on that?

Governor **Dukakis**. Well, the motorcycle constituency is not one of my stronger supporters, Senator. [Laughter.]

Senator **Chafee**. Well, I will join with you on that.

Governor **Dukakis**. But I believe the answer is yes.

Senator **Chafee**. I will send them to your office when next they come down.

Governor **Dukakis**. On the other hand, my State too has its problems. I mean, clearly, seat belts would be a major step forward. We passed a seat belt law, and it was repealed in a referendum; so, you win some and you lose some. But I think any of those reasonable kinds of safety procedures, particularly those that are likely to reduce the possibility of severe, traumatic, long-term paralyzing injury, are cost-savers.

Senator **Chafee**. Governor DiPrete, do you agree?

Governor **DiPrete**. Yes. There is no question that use of seat belts and helmets for motorcyclists statistically do reduce the cost of health care. That has been shown.

Senator **Chafee**. All right.

Next, do you agree that greater funding for community health centers is one expenditure we could make that would drastically reduce the financial drain on your emergency rooms in your hospitals?

Governor **DiPrete**. Absolutely. Again, it would be providing the necessary level of health care in a community, at an affordable or at least the lowest available price, without necessarily going to a more sophisticated hospital that has all the fancy gadgets, and people are paying for them, that aren't necessary in every single case.

Senator CHAFEE. Governor Dukakis, do you agree?

Governor DUKAKIS. I agree. But if every family and every citizen in this country had basic health insurance, then you wouldn't have to provide direct funding to many of these centers; they would be reimbursed through that coverage. And frankly, I think if you would talk to those who direct community health centers, they would love to operate in a situation where everybody who walked in the door had some kind of coverage.

Senator CHAFEE. My time is up, Mr. Chairman. Thank you.

Senator RIEGLE. Senator Chafee, I have been visiting hospitals in my State on that issue. It strikes me, that major hospitals, particularly big inner-city hospitals, have an enormous burden on their emergency rooms. Many people go to the emergency room for care that doesn't really require the high cost of an emergency room facility.

It may well be, we could help some of these hospitals under the greatest stress by having a community health facility that is open 24 hours a day, where non-emergency cases could be managed with a much less expensive service treatment mode. This is one way to start to rationalize this system.

I don't mean to take anybody else's time, but I have been struck by that during my travels.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. I would address this to both Governors.

Governor Dukakis, I agree very much with what you said about the insurance industry, and I think one of the untold stories now going on is that the Health Insurance Association of America and Blue Cross/Blue Shield really do understand that insurance reform is coming. It is interesting to me. I don't think they want to go back to community rating—which we recommended on the Pepper Commission along with eliminating pre-existing conditions, medical underwriting, guaranteeing coverage for all.

Governor DUKAKIS. Right.

Senator ROCKEFELLER. We also recommended that insurance companies be required to extend managed care to small group customers if they also offer that to larger groups within their service area.

I really think there is an enormous possibility there. That would make a lot of difference, don't you think, particularly to small business, in that the point of all of this is to try to make it possible for small business in fact to be able to afford health insurance? That is not just to say that they have got to have it, but that we really create a situation over a period of years, where they can afford it, which is what we do in the Pepper Commission, giving insurance reform a chance to work.

Do you believe, both of you Governors, that insurance reform is going to take place in sufficient measure over the next, let us say, 5 years, either on its own or with help and a nudge from us, as to make a difference for small business?

Governor DUKAKIS. Well, we are going to try to test it out, Jay, and I hope we can this year. We are working closely with our insurers and other primary providers to do that, so we will able to test this out for you a little bit.

I do think, in this area, that it would be enormously helpful to us at the State level to have many of you here in the Congress moving ahead with us on this.

As you know from your own experience as Governor, it is always difficult to break out of the pack, when you are trying to do something different that may be viewed as putting the industry at a disadvantage or under certain burdens in one State that don't exist across the State line.

I think if there is a sense that we are moving in concert together on the issue of insurance reform, it will make it easier for a number of the States to move ahead and to test out some of these concepts, with your strong support and help, and, conceivably, congressional action here that will help us to do that.

We would like to share that information with you. I know Commissioner Hooley has a lot of ideas already, based on the series of hearings that he has just concluded across the State, and would like very much to share that with you and to work very closely with you.

Senator **Rockefeller**. Thank you, Governor.

Governor DiPrete?

Governor **DiPrete**. Senator, I would agree with you, and I like the term that you used, "a nudge" from the Federal Government to the insurance industry, as opposed to a comprehensive regulation, if you will.

I am a supporter of keeping McCarron Ferguson, and I think most insurance rules, rates, and regulations, and so forth, are best handled at the State level. However, I believe there is an appropriate role for the Federal Government, such as malpractice, such as in products liability.

I don't have all the answers on that today, but I would see at least two areas in the insurance industry where there is a legitimate and appropriate role for the Federal Government that, frankly, the States can't handle by ourselves.

Senator **Rockefeller**. Let me ask another question of both of you. In the Pepper Commission we saw really a stunning and sometimes very discouraging variety in eligibility standards—for example, for AFDC, hence Medicaid—in different States. So, we recommended federalizing Medicaid, but also asking the States to continue to pay what they are now paying, approximately $12 billion, which may not be your happiest thought but, nevertheless——

We found in Alabama, for example, that a person must be at 14 percent of poverty to qualify for AFDC and hence Medicaid, and we just can't tolerate that.

So what the Commission has done, in a sense, is pre-empted the States in that respect, and I am interested in your views about that.

Also, we have set out a minimum benefit package that insurers would have to offer, which would not be a Cadillac package but would cover basic hospital, doctor, preventive, wellness, mother-and-children and other services.

How do you react (1) to the federalization of Medicaid, but nevertheless paying for it, at the rate that you currently are, about $12 billion; and (2) the pre-emption of State standards with respect to the benefit package, so that there is a common standard, and insurance companies would be able to offer more if people wanted to buy it, but that minimum package would have to be offered everywhere?

Governor DiPrete. Here, again, Senator, I think if Congress were to mandate certain basic coverage, certain minimum levels of coverage that must be available, that is fine, because I don't think the health care availability should depend upon what part of the country someone may be living in.

However, without Federal dollars to support the program, that would force most States into financial difficulty. Right now, the Medicaid portion of our overall State budget in Rhode Island is close to 10 percent. That is a significant figure. When I say 10 percent, that includes $400 million or $410 million that we return to the communities for support of local education. Even including all of that payback to the local communities, what we spend in Rhode Island on Medicaid is close to 10 percent of our annual operating budget.

Senator Rockefeller. Governor?

Governor Dukakis. And our percentage is higher, Senator. Now, part of that is because we happen to have one of the most generous Medicaid programs in the country. We are proud of that, and we hope we can continue to pay for it. But I think I can speak for a lot of Governors in this country who are having a very, very tough time making ends meet. And if you keep handing down these mandates, as you know, without the money to pay for them, we have to pick up 50 percent of the costs, and it is going to make it very difficult for us to keep going.

Senator Rockefeller. And we would do that. And I understand that. We all have this problem of how we are going to pay for this, and I understand it.

Governor Dukakis. Right.

The other thing we hope you won't continue to do is to do things that add costs. The repeal of Catastrophic Health Insurance will cost my State $100 million in additional Medicaid dollars, right off the top. You know, we just can't keep taking those hits; we have taken a lot over the past 10 years, and we can't take any more.

But I do think the fact that so many of you are deeply engaged in this, and providing leadership, that we are ready, as a group of Governors, on a bipartisan basis, to work closely with you. I think it is the best news we have had in a long time, and I think we can move ahead now and deal with these issues in what I hope can be a very close and collaborative way. We have done it before, and I think we all feel, just as Senator Chafee pointed out, that this is the single most pressing domestic issue we face in this country. I am encouraged.

Senator Rockefeller. Mr. Chairman, in thanking you I want to skillfully here add a word.

I so agree with the bipartisan comment that Chairman Riegle mentioned, which both of you Governors have reinforced. With the overwhelming nature of this problem, if we really can work together, and frankly if we can get the White House to work with us on this, too, we really can master this.

This is sort of an odd comparison, but we didn't know how to make synthetic rubber until the Japanese took over Indonesia and the Philippines in the Second World War, and then we had synthetic rubber within 6 months.

So I don't think you can deny what it is that we, working together, can do on health access and other health care issues, if we really do work together.

I thank the Chair.

Senator RIEGLE. Thank you, Senator Rockefeller. That is an important comment, and I think one we can all agree with.

Senator Durenberger?

Senator DURENBERGER. Well, let us see how close we are to synthetic rubber.

Let us start with the first question that the chairman asked you about, national solutions. I think we are all agreed we ought to have national solutions; but let us try something like Medicaid. Now, about 42 percent of the low-income folks are covered by Medicaid programs; 75 percent of the growth is going into elderly programs. We don't have a long-term care program in America. As you indicated, Governor Dukakis, we just repealed Catastrophic. It cost you $100 million because the 150 days of skilled nursing was lost in Massachusetts, and your chance to take care of the elderly or the disabled from a Federal program went out the window, so you are back to Medicaid.

Governor DUKAKIS. Right.

Senator DURENBERGER. Now, I don't think we are going to do that one in 6 months. I think the solution is at a national level, as we pointed out here, aiming it in the direction of a social insurance program, getting rid of the concepts of welfare.

Long-term care is the other part of it. I don't think we are going to do it overnight. I think it is an absolute essential, though, to deal with the 5.8 million people who, right today, are about 88 percent dependent on themselves, their families, or some other kind of a shoestring operation, before they go into poverty, in order to get into long-term care.

But I don't think a national solution to that is right around the corner, even if George Bush decided to give this full-time attention.

Medical technology we haven't talked about. You have got a medical alley, I have got a medical alley, everybody has got a medical alley. It is a wonderful thing; there has been a free ticket to medical technology. The latest anti-coagulant comes on the market for 10 times the cost of the old one, and everybody has got to put it in place, you know, because you get sued if you don't. And you can't do that in Rhode Island, you can't do it in Massachusetts—you can't put the curbs on it. But putting the curbs on it seems to me is not going to happen overnight.

Medical education? Medical Research? You have already addressed medical ethics. And since I don't agree with you on helmets and things like that, I suspect this debate is going to go on forever, on what we do about the ethics, and what we do about personal responsibility and lifestyle, and things like that.

When the United Auto Workers gets up here to testify and I ask them about the tax cap, they are going to blow off the wall on first-dollar coverage. You know, they want those $500-a-month plans, but they don't want to pay for them. And they are in the streets striking over these issues.

So I guess we could go on and on, and obviously in Boston if you talk medical education and you talk medical research, you are talking about the difference in a surgical procedure between an operation at Mass. General and St. Luke's in Duluth of about 50 percent, or 75 percent. And it isn't because it costs that much more to live in Boston. But trying to come to grips with that is a difficult problem.

So, that is sort of by way of saying I think we all agree that we need some national solutions, but I just can't believe they are as easy as getting the Japanese to make rubber. I don't say that to disparage my colleague; I just say that just putting our heads together and agreeing on these solutions is an important first step, but it still leaves us a long way from our goal.

So, in the meantime the Governors of Massachusetts and Rhode Island, it seems to me, are encouraging us to recognize that if we don't do something, the States are going to do it. And the States are doing it. And the States seem to be using a combination of employer-based health insurance mandates or payments into a fund of some kind, and then those State funds buy health insurance.

I think, Ed, you said that one of the things you are talking about is something I think they have already tried in Massachusetts, and that is to regulate hospital rates every year—you know, have a fixed budget for hospital rates—and now I hear the words "certificates of need" from you. I thought the last time we heard that was back in the Seventies someplace, when Jimmy Carter was—no, it went back to Richard Nixon, I think, and Jimmy Carter succeeded him.

But I see a struggling with the costs; I see the medical inflation going up 20 percent in Massachusetts last year. What I am wondering out loud about is how, while we are dealing with all of the tough national issues and trying to get consensus on helmets and lifestyles and social insurance systems, and for long-term care, and so forth, what are you going to be doing out there? I mean, what is possible for us to expect to see from the States?

When the small business community gets up here and says, "We can't afford that health insurance," I have got to believe them. When they say, "Ninety-four percent of us don't even want to be forced to do this," I have to believe them. So, where is the near-term solution going to come at the State level, where you mandate coverage but you can't control the cost?

Governor DIPRETE. Well, Senator, one of the things I indicated was that we are coming out with what you might call a "no-frills" medical care policy.

Now, there are going to be restrictions on there. The coverage will not provide health care for some of the more sophisticated procedures—in vitro, and some of the other services that have come along in the last few years. People, therefore, won't have the same level of health care as their neighbor across the street who works for General Motors, or whatever. However, it is probably one of the few effective steps that States right now can take on their own.

As far as certificate of need is concerned, in a relatively small State like Rhode Island, and I am sure the same is true in the

Commonwealth of Massachusetts, sometimes we are spoiled as to how far one must drive for a cat scan or a heart catheterization, or whatever.

In some of the larger States, these facilities are probably a couple of hours apart. I can tell you, in my State, people say, with the best of intentions—and really, they feel they are right—if their cousin in this city happens to have a hospital near by that provides a certain service, and they live 20 minutes away, and there is a hospital right near them that doesn't have that sophisticated machinery, then they feel somebody in State Government is not doing the job. Then you explain, "Well, this is a $5 million piece of equipment, and perhaps driving 20 minutes is not too much to ask in order to hold down everybody's health care bill." That is something, frankly, we do mandate in our State, and that is where the certificate of need comes in.

Governor **Dukakis**. Just to add to what Governor DiPrete has outlined, Senator, there is always going to be tension here between trying to keep costs down and, at the same time, encouraging the medical profession and our best health care people to reach new heights, develop answers to the problems of disease currently unsolved, and so on.

It is true that health care costs continue to rise—I don't think they went up 20 percent last year in Massachusetts, but they went up maybe 12 to 15, which is a pretty good-sized hike. On the other hand, we are blessed as the center of the biotech industry in the United States of America, with the possible exception of California, and it is going to be a driving force behind our economic growth in the Nineties and in the Twenty-first Century. I mean, you pays your money, you takes your choice.

That is one of the reasons why the costs at the MGH are substantially higher than they are at St. Luke's and Duluth, and for that matter at St. Luke's and New Bedford, for the same procedure.

I do think progress on the malpractice front is important. Our doctors are practicing a lot of defensive medicine these days, which is very expensive, and so some action on that front—which, as I have indicated, I think the States are in a position to take now, without waiting for you—is important.

We are looking at patterns of medical practice in cooperation with the medical society, to see if we can ensure that doctors are practicing good, thoughtful, cost-effective medicine that provides good care.

I mean, I think it is a full court press—you have got to do all of these things. And I do think that you have a right to look to the States to do a lot of that, because we have been in the business of trying to control costs for a long time, we do have that kind of experience, and we ought to be able to do it well at this point.

The only plea I would make to you is please don't keep cutting that Medicare budget and taking other actions here which massively shift costs to us and to employers.

Whether costs are up 7, 8, 10, 12, or 15 percent in a given State, premiums are up 20, 30, and 40 percent. Right? So the premium increases far exceed real increases in costs. And I think you know why that has happened.

And if this cost-shifting continues, I don't think we can deal with this problem of cost to employers, as well as to State Governments.

So I think we have all got to be a part of the solution, but we have got to assume the principal responsibility for dealing with the regulation of the industry in a way that keeps costs under control. I think the States have that responsibility, and we ought to be prepared to discharge it.

Senator RIEGLE. I want to make a comment before calling on Senator Kennedy, and that is: Related to this problem that you just cited, every single hospital in my State is under tremendous financial stress right now.

Last year in this country we had 65 community-based hospitals in various locations, that had to shut down. It is estimated that in Michigan we will lose 20 hospitals over the next 5 years. I don't know if many of them will be able to hang on that long. They are running up enormous losses, because the health care system isn't working properly. At the same time, we have tens of millions of people without any coverage at all.

So, I want to stress again that this subcommittee is determined to work on a bipartisan basis, not just here at the Federal level but with the Governors of the 50 States, to come up with a comprehensive health care plan that provides basic health insurance to every citizen of this country.

If we don't have healthy people who are able to work, we are not going to have a country that is able to produce.

We are going to do our best to get it done.

Senator Kennedy?

Senator KENNEDY. Thank you, Mr. Chairman. I have no questions. I think the committee is very fortunate to have both of these Governors speak on this issue. We can clearly understand that they have thought about these issues and they have made some tough decisions on it, and I think their guidance has been very helpful and very constructive.

I want to thank Governor DiPrete, and my friend, the Governor of Massachusetts, Governor Dukakis.

Governor DUKAKIS. Thank you.

Senator RIEGLE. We thank you both. You have been an excellent help to us, and we appreciate both the leadership over many years and the very important Statements today.

Governor DUKAKIS. Mr. Chairman, may I make just one concluding comment? Generally the Senator from West Virginia and I agree on virtually everything, and this is not by way of disagreement; but may I say this? I think this is easier than synthetic rubber. I really do.

I mean, at the beginning of World War II we didn't know how to produce synthetic rubber, but we know how to do this. We know how to do this. The question is, do we have the will, and the resources, and the commitment to do it? There is no mystery about it.

Our neighbors to the North, whether you like the Canadian system or not, our allies in Western Europe, and much less well-developed countries all over the world somehow seem to be able to provide their citizens with basic health security. And I refuse to believe that the United States of America, with all of our strengths, and all of our intelligence, and all of our will, somehow can't deal with this problem.

This is easier than synthetic rubber, but it is going to take a lot of work and a lot of effort, and we are just very pleased that you are providing the kind of leadership you are. If we can join together in early May in a good discussion, I think that will advance the cause. Then, we will take it from there.

Senator RIEGLE. Thank you very much for your very helpful Statements today. We appreciate what you have had to say.

Governor DIPRETE. Thank you, Mr. Chairman.

Senator RIEGLE. As we excuse our two Governors, let me now call our HCFA Administrator, Gael Wilensky, to come up.

Let me say we are very pleased to have you here. We will wait just a minute for those who must leave to do so.

[Pause)

Senator RIEGLE. We have some very important witnesses left to hear from today. Among them, Hon. Gail Wilensky, who of course serves as the Administrator of the Health Care Financing Administration.

I know you are under some time pressure today, and I want to say, at the outset, I remember when we had you here for your confirmation hearing. Many of us said and felt at the time, we would be getting strong and effective leadership from you. I think we are. So I want to thank you for that commitment, and say that we are very interested in hearing your comments today, particularly your views on the various cost-containment strategies, both generally and as they specifically apply to the Medicare and Medicaid programs.

We would be delighted to hear from you at this time.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. WILENSKY. Thank you, Mr. Chairman and members of the subcommittee. It seems like many, many months ago that I was here for my confirmation hearing rather than just a few short ones.

I am pleased to be here today to discuss health care cost containment strategies and the uninsured.

Cost containment strategies are an integral part of our mutual effort to assure Americans access to affordable, high quality health care. The Medicare and Medicaid programs have had significant experience with various approaches to restraining expenditure growth while maintaining or enhancing quality.

I offer you today what I believe are logical and prudent approaches to getting better value and better care for the health care dollars we spend.

Allow me to begin my remarks, however, by addressing our mutual concern for providing access to health care for the nation's uninsured.

This Administration is committed to expanding access to health services for America's most vulnerable families.

As you know, the quadrennial Advisory Council on Social Security will make recommendations on access to Secretary Sullivan this summer. Last fall, the Secretary directed an HHS Task Force to explore solutions to the access problem. I am now serving, as you know, as Vice-Chair of that group.

The President elevated the priority of this issue by requesting a Domestic Policy Council review of studies on the quality, accessibility, and cost of our nation's health care system.

These efforts underscore the Administration's highest-level commitment to marshalling the leadership, energy, and expertise necessary to address an issue that touches so many Americans. It would be premature and, indeed, impossible for me to forecast the outcome of these efforts that are now underway. But I look forward to sharing with you the results of the Administration's work in the future.

While we search for viable solutions to the problem of the uninsured, the Administration remains committed to implementing programs under current law that help ensure access. The Department's Maternal and Infant Health Initiative encourages States to offer Medicaid coverage of pregnant women and infants up to 185 percent of the poverty level.

Early and Periodic Screening, Diagnostic and Treatment, or EPSDT, is also a valuable benefit for our nation's children. We are working now to implement the OBRA 89 provisions regarding EPSDT.

Financial pressures of the current health care environment force us to rethink our concept of cost containment. The strategies that we have relied upon in the past have been a useful starting point, but they will be insufficient to control ever-increasing health care expenditures in the future. We must look toward more systematic approaches to cost containment, approaches that provide consumers, hospitals, and physicians with positive and appropriate incentives for controlling costs.

We must focus our cost containment efforts on securing better value for our health care dollars. Better value means improved access to high quality care. Better value means ensuring that the care provided is effective. Better value means eliminating unnecessary services. And better value means communicating with informed consumers and creating sound alliances with the providers of health care services.

One approach that we believe holds great promise for securing better value for our health care dollar is coordinated care. Coordinated systems of care encourage a wide variety of delivery arrangements such as HMOs and preferred provider organizations, or PPOs.

The Administration is committed to prepaid, managed health care. HMOs and other managed care plans have demonstrated their ability to provide quality care at an affordable price.

We also need to learn from the private sector. We would like to adopt successful innovations in the delivery of coordinated care, such as PPOs. We believe it is time to provide Medicare beneficiaries with an option in health care that consumers in the private sector have had for years.

Beneficiaries who enroll in PPOs would benefit from reduced premiums, coordination of services, and extra billing protection.

The desire for good quality health care, and to derive maximum value for each health care dollar invested, is the motivation for pursuing medical treatment effectiveness research.

The Department is pursuing an initiative designed to explore the effectiveness of medical practice through outcomes research and the development of practice guidelines. While the effectiveness initiative may give rise to program savings over the long term, its true value lies in the potential to enhance the quality of American medicine.

While we cultivate the effectiveness initiative and pursue coordinated-care approaches to delivering health care, it is important to support and encourage other cost containment mechanisms.

For example, we want to expand the current practice of bundling payments. A HCFA demonstration project, which will be implemented in the fall of 1990, will examine the feasibility and the cost effectiveness of a negotiated package price for heart bypass operations.

Selective contracting and competitive bidding are cost containment strategies developed in the private sector, but they also can be worthwhile strategies for public programs.

Some State Medicaid programs use volume purchasing arrangements and competitive bidding to purchase optical services, vaccines, and prescription drugs. All of these programs have reported savings.

Payment reforms are perhaps the most visible cost containment strategy. PPS and Medicare physician payment reform are examples of payment reform strategies that create better incentives to deliver health care more efficiently.

We are proceeding with plans to fold hospital capital costs into PPS, beginning October 1, 1991. Incorporating capital into PPS provides hospitals with better incentives to make prudent capital decisions.

Payment safeguards, such as medical review, provider audits, and assuring compliance with Medicare secondary payor requirements also have provided savings. Peer review activities, including utilization review, second surgical opinions, and pre-admission screenings are other useful vehicles to avoid unnecessary procedures.

Finally, beneficiary cost-sharing is another strategy to control overall expenditures. The challenge for us with beneficiary cost-sharing is to ensure that such requirements don't impose an excessive financial burden on beneficiaries or discourage them from seeking necessary care.

In conclusion, the challenges we face in addressing the problems of cost containment and access are very difficult. The viability of any proposal to enhance access will depend on the extent to which it can keep costs under control in the long run.

I look forward to working with you, Mr. Chairman, as well as with other interested parties, as we develop cost containment strategies for the future.

I would be pleased to answer any questions that you may have.

[The prepared statement of Dr. Wilensky appears in the appendix.]

Senator **Riegle**. Very good. I appreciate your statement today.

Is it fair to conclude that you think cost containment and access have to basically go together, have to go hand-in-hand?

Dr. **Wilensky**. That is correct.

Senator **Riegle**. You heard the testimony of the two Governors. They said, "Look, the States can plug ahead and try to do what they can, and there are certain things that each State is trying and is able to do; but they both made it very clear that we really need an encompassing national strategy to deal with this problem. Would you agree with that view?

Dr. **Wilensky**. I think there is definitely a role for the Federal Government in resolving this. I don't want to say that there is not a role for the States also, but the question as I was hearing it posed was, "Is it sufficient to let the States, each, independently, handle it on their own and do nothing more?" We believe, as an Administration, that there is a role for the Federal Government in resolving this.

Senator **Riegle**. I know that was a somewhat delicate question to answer, especially with studies in the works, and what have you.

I would certainly hope that the Administration would come to the view that the Governors are expressing to us, virtually en masse, that we really need a national strategy. There are things they can do, but they are very limited in what they can do. Part of it deals with the cost they and hospitals are being asked to absorb. In many ways, those costs are having a crippling effect.

You Stated before this committee in the past that it is likely that a public/private partnership is needed for universal access, and that the HHS Task Force will address this issue. Have the specific goals of the task force been developed yet? What does the task force hope to accomplish? Do we know yet?

Dr. **Wilensky**. The task force is serving now in a somewhat different capacity than when I spoke to you last because now the Domestic Policy Council is also working on the issue.

We are proceeding as we were in looking at the issue of the uninsured, and also beginning to develop the options to trying to look at the questions both for the uninsured and long-term care. But we are working in conjunction with the Domestic Policy Council, and there is an overlap between those groups that allows both groups to pursue their tasks in a natural and coordinated way.

Mrs. Horner, who is the Chair of our internal task force is chairing a Domestic Policy Work Group; the actual Council itself will be chaired by Secretary Sullivan as the relevant Cabinet Officer. I am working on this Domestic Policy Council Work Group.

So, the task force in the Department is laying out the basic options and strategies and looking at the dimensions of the problems of the uninsured and long-term care. It will be working with the Domestic Policy Council Work Group, and ultimately the Council in terms of reviewing the various strategies that have been proposed by other groups as well as those developed by the Department.

Senator **Riegle**. Let me ask you to highlight the factors which hold back HCFA's cost containment efforts, and discuss to what extent health providers and consumers have an impact on your efforts to try to achieve cost containment.

Dr. WILENSKY. I am not sure I understand the question.

Senator RIEGLE. Well, you are trying to control rising health care costs. I would like you to be very specific and blunt with us as to what impedes you the most. What is holding you back, what are the toughest things out there, the most unyielding, that we need to understand and think about in trying to presumably working with you, find a solution to control costs.

Dr. WILENSKY. All right. One of the issues that we have been concerned about has to do with the work on medical effectiveness. It has two reasons for being important:

The first is that we believe there probably are procedures that are done that are either unnecessary or of minimal value, and they are impacting not only costs but good quality health care.

But I believe there is a second area in which the effectiveness work may help us, and that is in tackling the malpractice problem. It has been mentioned today, earlier, by the Governors that they regard this as a serious issue. We also regard this as a serious issue.

It is difficult to quantify how much impact defensive medicine has had on physician behavior, but we believe it is a significant problem, and that the concerns for avoiding suits do lead to a defensive practice of medicine and unnecessary tests.

To the extent that appropriateness and outcomes work leads to practice parameters or guidelines, we think that may be very helpful in trying to set the standards of care that would be used in liability.

There is also a Domestic Policy Council work group on liability. It is headed by the Justice Department. Our General Counsel from HHS is a member of that work group. So we are also looking to see whether we can resolve malpractice issues.

Senator RIEGLE. Senator Chafee?

Senator CHAFEE. Thank you very much, Mr. Chairman.

Doctor, first of all I would like to congratulate you on the job you are doing at HCFA. I think it is splendid, and we are very glad you are there.

I particularly am pleased at the way you have separated the administration of Medicaid from Medicare so that it can be handled individually.

In your Statement you say, "Beneficiary cost sharing can help control spending, but must not impede access." Now, this is a very controversial topic, as you know. The UAW representative I am sure will say it is a disaster, "Don't talk to me about cost sharing."

However, I would suspect that cost sharing does restrain unnecessary visits to doctors and hospitals. The question is, what kind of cost sharing, and how do you assure that it doesn't impede access?

Example, there are things that I don't think are really cost sharing: It doesn't seem to me that a deductible is truly cost sharing, is it?

Dr. WILENSKY. No.

Senator CHAFEE. I don't think a premium payment is cost sharing.

Dr. WILENSKY. Not in the sense of effecting utilization, no.

Senator **Chafee**. You pay your premium, and after that it is allialli-in-free—"Don't hesitate."

Now, it seems to me the only kind of cost sharing that counts is a co-payment.

Dr. **Wilensky**. In changing utilization, yes.

Senator **Chafee**. In changing utilization, which is what we are looking at.

Do you have any suggestions on what percentage the co-payment should be? And, just to make it even harder, how do you make sure that it doesn't impede access? Should there be an income cut-off, so that cost sharing doesn't go below a certain income level?

Dr. **Wilensky**. I think there are two things to consider:

The first is to recognize that for some people the notion of having payment at a point of service is very troubling, and one of the advantages of having HMOs as an alternative care system is that people who are troubled by having their decision at the time of service being impacted by price, have a way to opt out of that kind of a system and to go to one where there is coordination and management of care.

Second, I think it is very important to understand, for those people who presumably will be making their choice at the time of purchase, how do they want to have their care impacted?

Senator **Chafee**. I didn't really understand what you were saying. Can you repeat that, with an illustration, maybe?

Dr. **Wilensky**. All right. I think an important point to recognize is that, while I as an economist believe that to have something priced at zero, which is what happens if you don't have a co-payment, will lead you to use a lot more—or some more, depending on what the service is—than if you do have a price. Therefore a co-payment is a good way to encourage cost-conscious behavior on the part of consumers. The other way to encourage cost-conscious behavior is to have individuals be part of a system where somebody else is trying to coordinate that care, not the person who is consuming it.

The part that is very difficult is if you don't either have cost sharing at the point of service in our fee-for-service system or have people in managed-care settings where there are some guidelines as to how you proceed, then there is no incentive to control utilization. One or the other needs to occur in order to have cost-conscious behavior on the part of the individual.

Some people find it very objectionable to have a co-payment attached to a visit, and those people can put themselves into a system where the incentives are very different, and where there is some management in the way that they use services—there is a gatekeeper effect, there are frequently protocols for utilization established.

For people who do not belong to such a coordinated-care system, then I believe it is in fact very important that they have some kind of cost sharing at the point of service.

With regard to the question you asked, there are some services where you probably are not going to want to do that. You are going to want to encourage as much consumption as you can. Those are things like immunizations or other types of health care that we decide as a society are so critical that we want them to occur, and we don't want to have any type of discouragement. But I don't think that is generally true. I think generally the level of copayment we typically use as 20 or 25 percent.

Senator CHAFEE. Of what?

Dr. WILENSKY. Of the charge.

But usually, when we do that, we do that up to some maximum amount—again, recognizing not that people wouldn't be affected beyond that amount, but that there is some point beyond which you don't want people to continue to pay.

Senator CHAFEE. Would you apply the 25 percent to everybody, regardless of income?

Dr. WILENSKY. Well, it is clear that people will be affected differently. And if you are willing to introduce the administrative complexity of having it vary according to income, you can do that.

When we considered catastrophic, for example, we didn't.

Senator CHAFEE. Let us not get into catastrophic right now. [Laughter.]

Senator CHAFEE. Briefly, in 30 seconds, have you got any studies to substantiate what you are saying? That cost sharing changes behavior as far as utilization goes?

Dr. WILENSKY. It changes behavior. There is some concern that——

Senator CHAFEE. I know you are saying that, but do you have any studies that you could cite to me or perhaps later on give to us?

Dr. WILENSKY. I would be glad to give them to you.

[Information Requested follows.]

Cost-sharing can be defined as financing arrangements whereby the consumer must pay some out-of-pocket costs in order to receive care. Most research in this area to date has focused on the general population, but recently completed studies on Medicare beneficiary use of health services has provided information on the comparative use of services by beneficiaries with and without Medicare supplemental insurance policies.

One of the earliest studies to examine the impact of insurance on the use of services among the general population (Scitovsky and Snyder, 1972, Scitovsky and McCall, 1977) assessed the impact of a 25 percent copayment for outpatient services on the use of these services among Stanford University employees during the late 1960s and early 1970s. The authors found that copayments reduced service usage substantially—by about 24 percent—and that these decreases persisted even several years after the copayments were instituted.

A study that has received considerable attention is the RAND Health Insurance experiment (Manning et al., 1987). Funded by the Health Care Financing Administration (HCFA) between 1974 and 1982, over 5,800 individuals in six sites across the United States were randomly assigned to one of several insurance policies containing varying copayment levels and out-of-pocket maximums. In general, the findings indicate that those with more complete insurance coverage had substantially higher amounts of service usage. Compared to those who paid almost all of the costs, individuals with no cost-sharing requirements were about 30 percent more likely to use any medical services during a year or to be admitted to a hospital. Total medical expenses for those with free care were about 45 percent higher, indicating that the majority of the impact of insurance was on the likelihood of using any services, rather than on increasing the amount of use among users.

Three recent studies have examined the impact of the ownership of Medicare supplemental health insurance policies on the use of services. Christensen, Long, and Rodgers (1987) found that ownership of a supplemental insurance policy increased the likelihood of having a hospitalization by 27 percent, but had no effect on length of stay.

Taylor, Short, and Horgan (1988) conducted a study based on data from the National Medical Care Expenditure Survey (NMES) They found that ownership of group policies increased hospital expenditures by over 30 percent, although nongroup policies did not have a significant impact. Similarly, group policies increased physician expenditures by almost 40 percent (compared to not owning a policy) nongroup policies increased physician expenditures by about 25 percent.

A third study by McCall and Rice et al. (1990), funded by HCFA, examined the effect of private insurance on beneficiary service use by compiling survey data, Medicare utilization data, and copies of sample members supplemental health insurance policies. The study found that utilization rates were similar for the total sample of those with and without supplemental insurance policies. However, the results show significant differences within subsamples of the study population. Compared to non-owners, policy owners who perceive themselves to be in fair or poor health use 31 percent more hospital days, 42 percent more Part B services, and have 36 percent more Medicare charges. In general, for individuals rating their health as either fair or poor, owning a policy increased both the probability of using any services, and the amount of services used among service users.

The main finding of the study was that ownership of supplemental insurance has a large effect on utilization and the cost experience of Medicare beneficiaries. Secondarily, perceived health status is an important factor in determining the magnitude of the utilization and cost. Furthermore, people who own supplemental policies with first dollar coverage, and especially those who perceive their health to be fair or poor with first dollar coverage, appear to have substantially greater Medicare use and cost experience.

Senator CHAFEE. That would be very helpful, because this is going to be a very controversial issue, as you gather.

Thank you very much, Doctor.

Senator RIEGLE. Did you wish to add something? I just want to make sure you have given the full answer you wanted to give.

Dr. WILENSKY. I have forgotten. [Laughter.]

Senator RIEGLE. All right.

Senator CHAFEE. She was talking about catastrophic. [Laughter.]

Dr. WILENSKY. The point on that is that we didn't want to have $2,000, or the total amount of the 1 day in the hospital or the physician payment vary with income. It was a decision made, I assume, balancing administrative complexity and other issues.

Thank you.

Senator RIEGLE. Very good.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Wilensky, you mention on your first page, "The Administration remains committed to expanding access to health services for America's most vulnerable families," and then you go on to the quad commission and the commission which you-co-chair, and then there is a lot of talk about cost containment. Then at the very end, your conclusion: "The viability of any proposal to enhance access will depend on the extent to which it can keep costs under control in the long term."

You are saying—are you not?—that there shall be no health care access initiative on the part of the Administration; cost containment is fully in place.

Dr. WILENSKY. I am definitely not saying that.

Senator ROCKEFELLER. Then prove to me otherwise.

Dr. WILENSKY. And it was certainly not my intent to say it, if you read it that way.

The point I was trying to raise is that both of these need to occur. I think we all understand that increasing access, to the extent we have not taken any steps to resolve the cost problem, will only exacerbate it, because it will have more people using the system.

I didn't intend to say, and I hope you don't read it in that Statement——

Senator ROCKEFELLER. It is the only way I can read it, because it is the only way it reads.

Dr. WILENSKY. Well, it is not either my intent, nor do I believe it is the Administration's intent, to not look at the access issue until cost containment is resolved; it is to say that both of these need to be looked at together.

Senator ROCKEFELLER. But is it not interesting, in a hearing called on the subject of access to health care and cost containment, that you devote literally two sentences to access?

Dr. WILENSKY. I think it is actually not "interesting," it is fairly simple to explain. The fact is, we are in the process of trying to decide, as an HHS task force and later as a Domestic Policy Council, the kinds of strategies to pursue with regard to the uninsured and long-term care. And the reason for only the few Statements at the beginning is because we are in process, and therefore I cannot tell you what type of strategies we prefer or what type of strategies we recommend.

I did, in fact, agree to come and talk about cost containment. I thought it was important, because this is an issue I know is so important to the Subcommittee, to indicate we also agree this is a critical issue. It has been elevated by the President in his State of the Union message; we are serious about this; and we are also serious about cost containment.

Senator ROCKEFELLER. And the President did mention health care. He talked about the cost of it and the quality of it. He did not mention the word "access" to it, just for the record.

Dr. WILENSKY. Well, we are looking at the issues of the uninsured and long-term care as we are proceeding with this activity.

Senator **Rockefeller**. I know you are involved in other commissions and other work, but nevertheless you can't be totally quiet until the HHS study is completed—or, you may choose to be.

Does the idea of health care coverage for pregnant women and children through the age of six, costing $3.4 billion, sound do- able to you in this country?

Dr. **Wilensky**. Is it do-able at any point? Sure. It could be doable. I think the question for the Administration is: How do we want to proceed in extending access? My own personal belief—and this is all I have to base on—is, until some decisions are made within these groups as to the kinds of strategies that will be recommended to extend access, I would be surprised if a major step is taken that assumes one kind of strategy or another.

So it is not a question of concern about pregnant women or concern about children; I think the President has made that clear in various Statements that he has made, and I think the initiatives that we are attempting to begin now during this process indicate that concern.

But whether or not we would go forward with the $3.4 billion, I think, at this point, is premature, because we haven't decided the strategies we want yet.

Senator **Rockefeller**. I understand.

You suggest the need for a systemic approach to cost containment, but you also warn against micro-managing the health care systems. Then you go ahead with a number of cost-containment suggestions which we mentioned in the Pepper Commission, and some that we did not.

Dr. **Wilensky**. Right.

Senator **Rockefeller**. And I think everything you say is very effective and very good.

Would you support more extensive government regulation of private health care costs and provider payments?

Dr. **Wilensky**. Well, those kinds of directions are not normally strategies. So I need to understand a little better about exactly what kinds of regulations you are thinking bout.

Senator **Rockefeller**. Doctor Wilensky, you have been in this field for a long, long time, and you know exactly what I am talking about. Just give me a sense, or decline to answer.

Dr. **Wilensky**. Well, we are in the process of implementing a massive change in how we pay physicians. The change itself, the payment reform, is not designed to save costs; but the volume performance standard is a way to try to do that.

We are proceeding with folding capital into the Prospective Payment System.

There are a lot of strategies that we are attempting to do, so it depends on exactly what kind of regulatory mechanisms you are talking about.

Senator **Rockefeller**. Okay. I respect that. Thank you, Dr. Wilensky.

Thank you, Mr. Chairman.

Senator **Riegle**. Thank you, Senator Rockefeller.

Senator Durenberger?

Senator **Durenberger**. Mr. Chairman, thank you.

We laugh a lot in this room, and in other places I guess, about the loss of catastrophic. Is the Administration considering some kind of a Medicare restructuring bill that would have catastrophic in it, at the present time?

Dr. **Wilensky**. Not that I am aware of.

Senator **Durenberger**. Do you think they should be?

Dr. **Wilensky**. If you mean going back to picking up pieces of catastrophic, there is a bill that has been discussed by Representatives Stark and Gradison to bring in four of the components. I am not aware of any other bill, and I am not aware of a bill by the Administration to do so.

I think, right now, the major attention I see being given is to the issue of the uninsured and long-term care, as first priorities. I believe that will occupy a large part of the next eight or 9 months. I think there is a lot of concern about addressing these issues in a way that will promote cost containment, not exacerbate it. This will certainly not solve all of our problems. However, I see that as the first priority.

I regard the Administration's commitment on the problems of the uninsured and long term care as very serious ones.

Senator **Durenberger**. There is an Administration task force or committee, or something, working on tort reform, and it has got a subcommittee on medical malpractice reform. Can we expect recommendations from the Administration on medical malpractice reform soon?

Dr. **Wilensky**. I know there is a task force. There is someone from HCFA serving on it. I don't know the likelihood of recommendations being issued, because I haven't be following it. I would be glad to get you an answer, if you would like that. I assume that is the direction they are trying to head, but I don't know where they are, and I don't really know the charge that they have.

[The information follows.]

For a number of reasons, there has recently been an increasing amount of attention focused on issues related to physicians' professional liability and the cost to physicians and to society of malpractice litigation.

Within the Administration, the Tort Law Reform Work Group of the Domestic Policy Council is currently examining a variety of issues surrounding the complex issue of medical malpractice. The Work Group, led by Stuart M. Gerson of the Justice Department, currently is working to develop options for addressing malpractice reform.

At this time, it is difficult to predict when the work of the group will be completed. However, I look forward to keeping you informed of the group's progress over the coming months.

Senator **Durenberger**. Is there anything going on in HCFA right now in the area of health insurance reform? We have heard from various people here about the HIAA initiatives and so forth. Are you doing anything special in HCFA right now that would lead to Administration recommendations on insurance reform?

Dr. **Wilensky**. No. But the insurance-reform issue is an issue that is being discussed within the task force, not within HCFA. But to the extent that I am on this task force, HCFA's views being discussed within the Department.

Senator **Durenberger**. You have heard the Governors testify earlier, or part of it, and I guess you know what they are doing in those States.

But it looks to me, unless we do something here fairly quickly along the lines of what the Senator from West Virginia is urging on us, that Massachusetts very shortly is going to have a mandated employer play-or-pay system in effect. It is also going to have in that State some kind of a State security fund for everybody. It already has mandated assignment for any physician who wants to practice in that State—I think I heard that.

Rhode Island will probably have mandatory rate-setting, and it talked about certificate of need. We went through this a few years ago, and Massachusetts was going to do rate-setting and all that sort of thing, and either they got discouraged or somebody discouraged them.

Assume mandatory rate-setting becomes the wave of the future, and we resort to enfranchising those high hospital rates in places like Boston. All those high doctor rates with a budget that is going to get paid for by the employers or somebody in Massachusetts, are we going to continue to contribute Medicare and Federal dollars into that kind of a system. A system where everybody pays the same rate into the Medicare system, but in Boston they take out twice as much as they do in Duluth, Minnesota, or something like that?

It seems to me one of these enfranchising systems is just that. I mean, are you going to let Massachusetts enfranchise their current system? What are we going to do about that at the Administration level?

Dr. **Wilensky**. We are taking more active steps to not have that happen in the physician payment than we are in the hospital sector, because of the way these rates are calculated.

Within the physician payment, that really doesn't become an issue anymore. The relative values are set according to time and intensity, with one component for practice costs. So, I think that is not an issue. You really wipe that out.

With regard to hospital payment, we are attempting, through our Prospective Payment System, to get around the pricing problem. It is more an issue, I think, of the variation in the volume than in the pricing. I think how much we want to do about that will depend on outcomes and appropriateness; whether we are really going to be in a position to try to go after the high variations that are not only between Minnesota and Massachusetts but are between parts of the Northeast.

To the extent we do not know how long it will take for us to come to some decisions about what direction to go nationally, I think the plans that are being discussed, including the plan in Massachusetts, may provide us with some very important information. There have been a lot of us who are concerned about the impact of that program.

Senator **Durenberger**. Let me interrupt you, just for a last question.

One piece of information I got just a little while ago from the Governor of Massachusetts is that they are not going to restrain the costs in Massachusetts, other than by some kind of a budget mechanism, because just before he walked out of here he very clearly said that it is our fault that insurance rates are high in Massachusetts. I believe I am quoting him correctly.

He said "The Federal Government has been cutting Medicaid, it has been cutting Medicare, we have got to stop cutting Medicare, and so forth, because all of the excess costs are being shifted over onto the third-party payors."

Now, first, that is not true.

Dr. **Wilensky**. That is definitely not true.

Senator **Durenberger**. I mean, we have not been cutting Medicare. Second, his charges may be high in Massachusetts, but his costs aren't any higher than they are in Minnesota for the same procedure; but his doctors and his hospitals have gotten very used to charging whatever they please. And if in fact, in this place, we decide that we are not going to continue paying them twice as much as they get in Minnesota, I don't know why we should get blamed for that system.

But it strikes me that he and perhaps others, similarly situated, who can't control their own costs in that State—and I understand some of the difficulties—are going to end up blaming us for the problem. And yet, I just don't see it as our problem.

Senator **Rockefeller**. Was that it, Senator Durenberger? [Laughter.]

Senator **Durenberger**. The red light is on.

Senator **Rockefeller**. I am scrambling here.

Senator Chafee, did you have any other questions?

Senator **Chafee**. No, I didn't.

Senator **Rockefeller**. Oh, the Chairman is here. I am sorry.

Senator **Riegle**. I am told that there is a rate-setting procedure for hospitals in Massachusetts, although I am certainly not an expert on that subject.

Dr. **Wilensky**. Right. Four States have State rate setting.

Senator **Riegle**. Pardon?

Dr. **Wilensky**. Four States, of which Massachusetts is one.

Senator **Riegle**. So there is some effort in place to try to deal with that, I take it.

Dr. **Wilensky**. But, nonetheless, they have very high rates. The argument would be: not as high as they would have had if they didn't have rate setting.

Senator **Riegle**. Is the teaching hospital aspect of that a load-on factor, or not?

Dr. **Wilensky**. Well, as to the issue about why some places have higher expenditures, there is no question that there are great variations in the rates of charges that you see around the country, and there are great variations in the level of use that you see around the country. There are a lot of different reasons for it. Some of it is the concentration of technology, some of it is the concentration of teaching hospitals, and a lot of it we don't know why it is.

One of the most interesting aspects of the variations and appropriateness literature is the difficulty of trying to explain why it is we see these great variations in practice style—and the term that is usually attributed to it is "variations in practice style." It doesn't correlate with anything very obvious. It doesn't even correlate very well with appropriateness. So you would think a State that had a very high level of variation might be more expected to have a lot more inappropriate care than one with a low level; that if they had a low level they are probably doing what they need to do. That doesn't correlate very well either. There is a slight relationship, but there is a tremendous amount of variation, and we are trying desperately to try to understand it and to sort out the stuff that is appropriate and that which isn't.

Senator **Riegle**. Very good.

Gentlemen, I think if there are no other questions——

Senator **Chafee**. Could I ask just one, please?

Senator **Riegle**. Yes, of course.

Dr. **Wilensky**. Sure.

Senator **Chafee**. Doctor, you talked about malpractice, and you indicated you believe it should be changed. If we are going to do that, it is really going to require great assistance from the Administration, which is you in this instance. And I, for one, think many are prepared to tackle that. But there is great resistance from not only some Senators but a group out there, trial lawyers who are against malpractice reform. So I think it is a key ingredient in holding costs down.

Dr. **Wilensky**. As I said to Mr. Durenberger, I will be glad to provide you with information on where this task force headed by Stewart Gerson of the Justice Department is and what their anticipated product is.

[The information follows.]

For a number of reasons, there has recently been an increasing amount of attention focused on issues related to physicians' professional liability and the cost to physicians and to society of malpractice litigation.

Within the Administration, the Tort Law Reform Work Group of the Domestic Policy Council is currently examining a variety of issues surrounding the complex issue of medical malpractice. The Work Group, led by Stuart M. Gerson of the Justice Department, currently is working to develop options for addressing malpractice reform.

At this time, it is difficult to predict when the work of the group will be completed. However, I look forward to keeping you informed of the group's progress over the coming months.

Dr. **Wilensky**. What I have been concerned about in the past is that the Federal Government has had, except for very narrow circumstances, limited ability to deal directly with this, because this is typically State law.

Now, I don't know what this task force is proposing, so I don't want to indicate that they are either taking that view or another view; but, in the past that has certainly presented great difficulty.

I do think this appropriateness and effectiveness guidelines might help at least set out the standards for medical practice as to what would be regarded as the standards of care in a community.

Senator **Chafee**. Thank you.

Senator **Rockefeller**. Mr. Chairman?

Senator **Riegle**. If I may, before yielding to Senator Rockefeller, I spent 12 years on the Commerce Committee and had any number of hours of discussion on that issue.

At one point when we were moving ahead in that area—I was working with Senator Kasten, who has been involved in that on a bipartisan basis. We asked for the data, to try to determine the costs and the premiums, and whether the costs were driving the premiums to extraordinary levels. We were getting appeals from the insurance industry to come up with some kind of a Federal response to the problem. We were told that we couldn't have the data. I am paraphrasing, but the essence of it was, "Take our word on the data. We would like you to fix the problem, but we don't really want to give you the numbers." And we were just beginning this discussion.

But I think, to really get into this, we are going to have to get our hands on some data—albeit the McKerran Ferguson Act being out there, and the States handling the insurance issue, and so forth. To get cost information that we can do something with, we have to request it, and be darn sure we get it, so that we know what we are talking about.

We don't have a lot of expertise at the Federal level on the insurance business. But I want to get the data. I want to fix the problem. And to do it right we have to get the information.

I am not quite sure what that answer is, but I just tell you that because I found it very hard to get the data in the past. I don't know that it will be sort of sent under our door tonight in a sealed envelope; I think we are going to have to go out and work very hard to get it.

Dr. **Wilensky**. I assume you know there is a recent study completed for the State of New York by Harvard University. That is one of the few recent empirically-based studies that I am aware of.

Senator **Riegle**. Thank you very much for your testimony. You have been helpful to us today, and we appreciate your coming.

Let me now invite to the table our final four witnesses for today, and we are very pleased to have them:

Mr. Robert Hungate, who is the Government Affairs, Health Care Manager for the Hewlett-Packard Company. He is actively involved in leadership roles in a variety of health-related organizations.

Mr. Walter B. Maher, Director, Human Resources Office, the Chrysler Corporation, and an excellent witness in the past. He will discuss the impact of high health insurance rates on industry and recommend possible policy changes.

Also, Mr. Michael Roush, who is the Assistant Director of Senate Federal Government Relations for the National Federation of Independent Business. He will be outlining for us the special problems of small businesses in providing adequate health care coverage for employees and their families.

Finally, and last but by no means least, Dr. William Hoffman, who is the Director of the Social Security department of the United Auto Workers. Dr. Hoffman will underscore the importance of access to comprehensive universal health care coverage for workers and their families, and he may have an opportunity to respond to some of the other comments made earlier in the day.

So, gentlemen, we welcome all of you. Mr. Hungate, why don't we start with you?

Let me just say, at the outset, I am going to have you pull the mikes close to you so you can be heard. We will make your full Statements a part of the record. I apologize for the lateness of the hour in the afternoon, but we wanted to move ahead on this. I am going to ask you to summarize as much as you can, so we have time to get into the exchange.

Senator **Chafee**. Mr. Chairman, I have to leave in five minutes, but I just wanted to say to the witnesses I regret that a prior commitment requires it. But I will read over your testimony, because I think what you have got to say is going to be interesting, and I apologize for having to leave.

STATEMENT OF ROBERT W. HUNGATE, GOVERNMENT AFFAIRS, HEALTH CARE, HEWLETT-PACKARD, WASHINGTON, DC

Mr. **Hungate**. Thank your for the opportunity to input. There is no way I will read all this testimony. I would lose interest, as well as you. So what I will try to do is paraphrase the pieces and go through it there.

Senator **Riegle**. Very good.

Mr. **Hungate**. You are dealing with a critical issue, a complicated issue. I can tell by the questions I hear that you are serious about it, and we applaud that activity.

I am speaking today on behalf of Hewlett-Packard Company. I serve as the corporation's Government Affairs Health Care Manager.

We just celebrated our fiftieth anniversary last year and employ about 95,000 people, two-thirds of whom are in the United States, and we had 1989 revenues of $12 billion. Half of those revenues came from outside the U.S., making us the twelfth largest exporter in 1988.

In 1989 we spent about $152 million providing health care benefits to our U.S. employees—past, present, and their dependents.

We feel our efforts have kept our costs about 30 percent below where they would have been without the cost containment initiatives that we have put in.

About half of our employees are now in HMOs, and in New England it is up to 70 percent. I also live in New England, and so have experienced the debate in Massachusetts, and serve, among other roles, as the chairman of the Health Care Subcommittee for the Associated Industries of Massachusetts, and there will be more to the Massachusetts story as it enfolds. There are multiple views, as you might imagine.

I also serve here in Washington as Co-Chair of the Health Care Committee of the National Association of Manufacturers and on the board of the Washington Business Group on Health.

Paraphrasing across the comments that I have got here, the second page just covers the cost problem from my home town. I live in Wellesley, and since 1987 health care costs for the town of Wellesley has gone up by 167 percent. We are pooled with a group of other communities. That health care cost increase has eaten up all the increase in city budget that came from State support. So, it is a major problem for this town.

Cost is, in fact, the small business access problem. Unless we grapple with that cost issue, we are not going to make much progress on the State problems.

My comments are based on agreement, with the recommendations of the Pepper Commission, that the employment-based system for providing health benefits to people will continue, expand, and be improved.

The employer-employee political arena provides a largely self-correcting system. It is a democratic strength that we have that process operating.

Benefits managers? I didn't grow up in the benefits world, and I have learned to respect the task that they have as being very similar to the task of Congress, in the sense that "what have you done for me lately?" is an ever-present question.

Just as you must manage the benefit for Medicare beneficiaries, a benefit manager does it for a large company's employees, and suffers conflicting pressures. The President is after him every minute for the cost of health care, and he is after him every other minute for the complaint from an employee for a denied procedure. So, there is a balancing there that comes home in the benefits manager that is very like what you deal with, with the Medicare beneficiaries.

If you think about the difference between a large employer and a small employer in that context, the large employer has someone to deal with these issues; the small employer does not. The small employer's benefit manager for health care is an insurance broker, and that is really where it comes from. It is dramatically different. Motivations of an insurance broker for a small business owner are quite different than a benefit manager for a corporation. I think that Congress or State legislatures, as the case may be, will be basically stepping in for the benefit manager of small companies, acting on behalf of the business owner, for those employees and the owner.

My remarks today do not offer a quick fix. Hewlett-Packard has implemented many fixes; each has revealed what we had to do next. Our strategy for managing the cost, basically, is to design programs which encourage employees and providers to make medically-sound, economically-efficient health care decisions. That is attended by a continuation of providing health care alternatives, and a continuation of monitoring utilization and costs.

I should make it very clear that the motivation of our employees is a more critical factor to Hewlett-Packard for business success than is our ability to reduce health care cost. We have got to have motivated employees on all fronts, and just health care cost is a much smaller factor than the motivation of those people.

Employees really are looking for health status, not really health care. I have enumerated, on the fifth page of the testimony, a lot of specifics that we are doing.

I was pleased to hear Gail Wilensky refer to the initiatives that HCFA will undertake on heart transplant programs. That is one of the things we have done, is gone to a global purchasing of heart transplant for any of our employees that need that, where we have selectively contracted with an individual hospital. It was quite a challenge to demonstrate that we could both provide high quality and low cost.

Let me move from immediate actions to some thoughts about elements to consider for the future:

In talking about cost management, it is essential to consider what must be managed. In comparing the U.S. system to others, I conclude there are three primary areas adding cost without appropriate value. The three, which were mentioned earlier today, are malpractice, administrative costs, and inappropriate use of technologies. Through a series of analytical steps, I think you can ascribe about 1 percent of GNP to each of those.

On administrative cost, if you compare the U.S. and Canada, Canada costs about 8 percent of their health care cost in administration; ours is about 18 percent. That is a 1-percent of GNP, by the time you work through it. On malpractice cost, frequently it is Stated that defensive medicine is a cause of 10 percent of the procedures. If that is true, you are at another 1 percent, which I think underscores the importance of both of those.

We should not be surprised by health care cost inflation. We have a cost reimbursement system, the same one that yields $600 hammers in defense procurement. We have insulated patients from costs, fueled their expectations of being cured by broadcasting the marvels of modern technology. Given our national mindset for action, "Don't just sit there, do something," it is no surprise that treatment patterns are more aggressive here than in other countries. Not only that, we provide tax incentives to insulate the individual from costs if his or her employer pays the bill.

We have generated as part of this a public expectation that, if you spend enough, you will get the very best care. Individual expectations are critical to effective health care cost management. Gaining an understanding that less may be better is a major part of our common challenge.

At the top of page 8 is a diagram that I found useful in thinking about why you might get higher quality if you spend less money. The health care cost factors are on the left-hand side of the page, where you do things to patients, at a price, with an outcome; those things that are necessary and appropriate, or efficient, or effective; and there is an is/is-not process. So if they are non-effective, or non-efficient, or not necessary, then they are non-quality, and the inverse is quality.

The continuous quality improvement model that industry is having great success with involves getting rid of non-quality things in order to improve quality, and this is a way of portraying how that can operate within health care.

Moving on to page 9, toward the bottom there, I advocate that we begin to think about health care in four categories and not just continue to lump it into one big bushel basket.

I think, in order to really measure what is going on, we are going to have to think about primary care as distinct from chronic disease management, as separate from diagnostic services, as separate from major episodic management. Each of them has different characteristics in terms of the patients' expectations, their sense of what will occur, and hence there are different ways to manage the process of provision of the best answer.

I have talked a little bit more about each of those on page 10 and 11, and I would like to close with the Statement that Hewlett-Packard and the Congress have a common challenge in assuring that our constituencies receive high-quality, cost- effective health care. Our beneficiaries' perception will be the reality of how well we accomplish that. Good information, well presented, not about costs but about outcomes—results—is our best means of managing the systems.

In thinking about expansion of access to under-served populations, cost management principles must be observed. That requires attention to incentives for the individual, the care providers, and financial sponsors, be they government or employer. When we say "access," do we mean the same insulation from costs of the health care system that has fueled our current system? I think not.

I think attention to the demographics of the populations to be addressed, attention to primary and chronic care first, careful thinking on the cost-management challenge, and attention to the need for true protection from financial disaster for the individual, the care provider, and the sponsor will be essential to establishing the political base that will be necessary for improvement on the access front.

Because the high costs have restricted the continued expansion of coverage, this must be addressed. The two most critical are malpractice costs and associated defensive medicine. Public information about quality of outcome by the provider may be the best ultimate manager of improved outcomes. The second critical area is the small business market, where both coverage definition and underwriting practice, as discussed earlier today, really need significant change.

Hewlett-Packard looks forward to continued discussion with you on this critical issue.

[The prepared Statement of Mr. Hungate appears in the appendix.]

Senator RIEGLE. Thank you very much, Mr. Hungate, for a very thoughtful statement. Your testimony is helpful to our efforts and is greatly appreciated.

Mr. Maher?

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, HUMAN RESOURCES OFFICE, CHRYSLER CORPORATION, WASHINGTON, DC

Mr. MAHER. Thank you, Mr. Chairman.

We are gratified that both the Pepper Commission and your working group have addressed both the high cost of health care in America and the large number of uninsured. These two issues are inextricably linked.

No nation on earth has embarked on a program of providing all citizens access to health care without concurrently adopting a strong, coordinated plan to help assure control of costs. This is an extraordinarily important fact, and we urge you to keep it in mind constantly, as there are many forces at work who will try and convince you that tough cost controls are not possible in America. They are, and they must be.

My company is quite concerned about the competitive damage inherent in the dramatic difference between U.S. and foreign health costs. Seven hundred dollars of the cost of every U.S.- built Chrysler car goes to support the U.S. health system. We must compete with foreign auto makers having a $300-500 per car advantage over us due to health costs alone.

The Pepper Commission and working group recommendations address many concerns of the business community—the expansion of public program coverage for the poor is long overdue, as is increasing Medicaid reimbursement for doctors and hospitals. All publicly-financed health programs should be operated so as not to cause providers to shift costs to the private sector payors. This, I submit, is a must if we are to go forward with a public- private partnership in addressing the health care issue.

Malpractice litigation reform is likewise an urgent problem requiring immediate attention at the Federal level, and we are pleased to see it prominently mentioned.

The Pepper commission recommendations were much less aggressive than we had hoped for regarding overall health system cost control. Expenditures for capacity expansion and renewal and for technology development and diffusion merit special attention. Further, the subject of medical education expenditure requires scrutiny. Finally, establishing a process to help assure aggregate U.S. health expenditures are more consistent with effective medical practice and costs in other leading countries is a concept we believe deserves to be included in any health system reform package.

While we believe participation by all employers in the financing of health care is an essential ingredient to a solution, we concur with Senator Rockefeller that the Government cannot reasonably mandate participation in a health system that is broken.

One way to address this matter and to accelerate the whole system reform process would be for government to take the steps necessary to assure that the new public program or programs contemplated by the Pepper Commission recommendations be models of efficiency, with built-in spending controls such as expenditure targets or volume performance standards, except applicable to all services.

Any individual or employer should have the option of buying in to such a plan on a community-rate basis, which should serve to spur the private sector to come up with even better products.

Now, some may reasonably ask: What assurance is there that government can run an efficient system? I submit, it all comes back to a requirement that government be required to pay fairly for services rendered to Medicare and Medicaid beneficiaries, including its fair share for hospital capital and medical education, and not have the latitude to cost shift. Given that constraint, coupled with constraints posed by the deficit and by the undesirability of raising taxes or diluting the quality of the programs as means to control cost, then I believe government will be compelled to run an efficient health plan, one embodying the best managed care techniques available.

Now, if my hypothesis is wrong, then very few if any would buy into such a plan, choosing instead more efficient private sector plans, and the only complaint Congress would have would be from taxpayers complaining about the high taxes required to run such a program, rather than the complaints being heard today from the uninsured about lack of coverage and from business complaining about cost shifting, which is as it should be.

Concerns of the very small business person significantly impact this problem. Seventy-five percent of U.S. businesses employ fewer than 10 persons. The majority of them do not currently offer health coverage. In the aggregate, 46 percent of U.S. employers do not offer coverage. Now, while they employ only 15 percent of the nation's workers, they represent an obstacle to universal access if employer-based coverage is to be the chosen financing vehicle.

Now, if the concerns of these employers cannot be satisfied because of worries about tying health coverage to employment and the resulting impact on hiring and production cost, and as a result the health system reform needed by all employers is stalemated, then we believe it would be appropriate to reconsider the tie to employment and find some alternative way for all businesses to help contribute to the support of the U.S. health system, such as through the tax system.

In conclusion, the process of accomplishing health system reform will be very tough, but it will be tougher if we delay. While we can appreciate how this process of reforming a broken system must take seriously the concerns of hospitals, physicians, and insurance companies, the overriding need of American citizens and American business to have an affordable and cost-competitive health system demands that we not overconcern ourselves with having to build on a shaky foundation. Any final legislation resulting from the Pepper Commission recommendations or from the options presented by your working group, which presumes a continued role by business in financing health care, must consider how that role will affect the cost of production in America and the resulting impact on international competitiveness.

We look forward to cooperating with you as the reform effort works its way through the legislative process.

[The prepared Statement of Mr. Maher appears in the appendix.]

Senator RIEGLE. Thank you very much. I think that was a very important and valuable statement, and I appreciate the work you have done. You have also testified before other hearings we have had in Michigan. I appreciate it.

Mr. Roush, we would like to hear from you now, please.

STATEMENT OF MICHAEL ROUSH, ASSISTANT DIRECTOR, FEDERAL GOVERNMENT RELATIONS, SENATE, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC

Mr. ROUSH. Mr. Chairman, thank you very much.

Given the lateness of the hour and in order to expedite the proceedings, if you don't mind I will just wait for questions. You have my Statement and a summary. I would, if I could, just like to introduce one additional bit of information into the record.

Senator RIEGLE. Please.

Mr. ROUSH. If that is okay with you, I would prefer to do it that way, just to expedite the proceedings.

[The prepared Statement of Mr. Roush appears in the appendix.]

Senator Riegle. This is my twenty-fourth year here, and that is the first time I have ever seen that done. So, it just shows you that if you wait long enough, you will see anything at least one time. [Laughter.]

Senator **Riegle.** And Dr. Hoffman, who is going to follow you, just slipped a note up to me and said he would like to have your time, in light of the fact that you have yielded it back. [Laughter.]

Senator **Riegle.** Dr. Hoffman?

STATEMENT OF WILLIAM S. HOFFMAN, PH.D., DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UNITED AUTO WORKERS), DETROIT, MI

Dr. **Hoffman.** Senator, it won't be the second one in your 24 years. I do have a few comments that I would like to make.

I appreciate the opportunity to be here today. I represent the 1 million active and 500,000 retired members of the UAW. I will try to summarize my comments and add a few comments to the printed text and then take questions.

UAW collective bargaining agreements with major automobile, aerospace, agricultural implement companies and a variety of other public and private employers provide health insurance benefits to workers, retirees, and their dependent family members. These programs, as well as the jobs of the workers covered by them, are threatened by the onrushing increases in health care costs.

I would like to put this in some perspective, because I think we tend to look at this in terms of the present day. I would like to step back for a second and talk about it, because we have been looking for studies. I think we have had a decade full of studies.

Throughout the 40 year period ending in around 1980, the number of Americans with health insurance protection continued to grow. The establishment of Medicare and Medicaid in the Sixties were great breakthroughs.

The American public bought the promise that voluntary health insurance would eventually reach the rest of the population; there was room for all of us under its umbrella. That umbrella would shelter the millions of Americans who live from paycheck to paycheck from the otherwise devastating cost of paying for personal health care services at the time of illness.

Private sector business also accepted the proposition that the public interest required a transfer of economic risks of illness from workers to employers. It was understood that, in a way uniquely American, the private sector of the economy was taking on this role so that government would not have to.

However, by 1980 it became evident that a voluntary approach would never begin to finish the job. The umbrella had begun to unravel. For the first time, the numbers of Americans without health insurance protection began to increase.

Employers, almost apologetically at first, became uneasy about the increasing cost of sponsoring health care plans. Soon they began looking for ways to just cut their costs. The more aggressive cost-cutters, particularly at small firms, if not restrained by a collective bargaining agreement with a union, simply ceased to sponsor employee health care benefits.

Other cost-cutting techniques developed, including: reducing or eliminating specific benefits, adding or increasing deductibles or copays, introducing or re-introducing or increasing periodic worker contributions for health care insurance, offering employees bounties or some other incentives for declining health care coverage, reducing or discontinuing retiree dependent coverage, introducing coverage restrictions and benefit limitations, utilization controls, and introducing and creating alternative delivery systems—the HMOs, PPOs, et cetera—of exclusive providers.

Because we have contracts with so many different types of employers across the country, large and small, manufacturing, both public and private, we have had first-hand experience with almost every one of these approaches.

The need for fundamental reform for our health care system is becoming more urgent daily. Narrowing of access, inflation, and unevenness in quality appear to be growing worse.

The private sector, however, appears to have run out of credible solutions to this set of complex and interrelated problems. The entire U.S. health care system needs reform and redirection.

You don't solve the problem by cutting needed protection. I oftentimes am privileged to sit in rooms represented by government, business, hospital administrators, insurers, physicians, others, and we all sit around and say, you know, with all these powerful elements, with labor represented there, and we say, "Let Mikey eat it." And it strikes me a little bit strange, after a decade of cost-shifting, cost-sharing, increasing, that the patients are the ones that we are looking to to solve this problem. We have had a decade of this approach. You know the results. It is the reason we have this hearing today. Health care is a unique commodity. The health care system is provider- driven. Sure, patients should ask questions and plan active roles; however, decisions by the consumer—that is, the patient—have minimal impact on system costs when compared to the decisions and practices of providers, doctors, hospitals, drug producers, medical equipment suppliers, insurance carriers, and a variety of medical entrepreneurs.

Recently, with the growth of individual practitioners being business-type people, selling their own services and self- dealing, making patients pay more in the name of "system reform" just doesn't make a whole lot of sense.

You all know about the recent contract disputes in major corporations. We have had them. We expect to have serious problems, both in the large employers and in smaller employers, across the country, and I would like to just tell you one experience, because the competitiveness of this is striking. It doesn't matter your philosophy. I have fairly strong beliefs and have held them for a long time; but let me tell you, as a person who does collective bargaining for a living, you have to be pragmatic.

I would like to compare bargaining with the same corporations in the United States and in Canada. Over 15 years of collective bargaining experience in the United States, in 40 States, with all kinds of firms, I have never been to a bargaining table where health care costs, quality, and access for our people weren't a critical if not the critical concern.

It is like we are trying to solve our nation's health care concerns at every collective bargaining table, and I would assume it is the same for those employers who aren't privileged to have a union representing their employees.

Let me now compare that with representing the same employers in Canada. Oftentimes we share a plane, private or public transportation, moving to Toronto from Long Beach, California, for an aerospace company—having completed negotiations in Long Beach, we would go to Toronto.

In Canada, our major debates are over whether or not we should upgrade to semi-private room from ward coverage in a hospital. Our discussions center on whether or not shampoo should be included in a prescription drug program, and whether or not oversized lenses should be included in a vision care program. Health care is in the area where it can be dealt with, where everybody has access to decisions that affect the lives of the people and how health care is delivered; it is not done on the whim or the decision of health care givers at the point of service.

Let me conclude. I appreciate your allowing me to comment just a little longer.

It is my considered belief that if we don't locate places in this country where all of the concerns are dealt with in a unified manner, and that is in the Federal Government and within each State, we are going to continue to have the problems that are before us and, unfortunately, we would have to hold hearings like this again in the future.

As you know, we have been proponents for a national health insurance program for years and years and years. We continue to be that way. At the same time, we welcome this public debate. We think we ought to all sit down and try to solve the problem at this point, and not preclude any alternatives before we all get under the same tent to talk about the common problems.

With that, I commend you for holding the hearings, and I appreciate the opportunity to be here.

[The prepared Statement of Dr. Hoffman appears in the appendix.]

Senator RIEGLE. Thank you very much.

Mr. Roush, I don't know whether you want to take a paragraph or two out of your Statement, or you just want to say with your original——

Mr. ROUSH. I think I will stay with the original.

Senator RIEGLE. All right. Very good.

Mr. ROUSH. It is too tempting at this point.

Senator RIEGLE. Let me ask you this, and let me address this to you, as you represent the NFIB:

We all recognize and appreciate the fact that this problem tends to fall differently, given the existing health care system in this country, on smaller businesses than on larger businesses. By that, I don't mean to say that it is not, in a sense, an equal difficulty; but the scale of the operation obviously affects the situation. And in other ways, whether workers are healthy and whether they are distracted in worrying about their family with a health problem, or what have you, obviously has a bearing on any company. It may actually have a bigger bearing on a smaller company, that you lose a key employee in a small company to an illness, or they are distracted because of family health problems. I think it can actually have more of a crippling effect on a smaller business, at least many that I would be familiar with.

Would I be fair in concluding that the small businesses that you speak for today would like to see some kind of a national program, of some sort, some balanced sort, that would see to it that all workers in the country—not just workers, but I am addressing it now to workers—that all workers would have access to some affordable health insurance system that keeps them healthy, on the job and productive?

Mr. ROUSH. Sure.

Senator RIEGLE. Has the NFIB taken a public position to that effect?

Mr. ROUSH. Our members, and small business in general, want to offer health insurance to their employees; but, as has been Stated by many of the witnesses today, cost is the problem.

The way you pose the question I think gives problems to small business people, though. "Access," frankly, is a mystifying concept to me and to them. All of the discussion here is cost- containment and "access." But what is "access?" What does it mean? They don't know what it means, and they are afraid.

You mentioned, and the gentleman at the end of the table here mentioned, coming "under the tent" and not excluding anything. Well, small business people, as I say, want to provide health insurance. Cost is the problem that they see. But they are not willing to enter into that tent, frankly.

I know you know this, but I will re-emphasize it: They are not willing to enter into that tent if mandated health insurance is included in the discussion. They would just as soon not participate in that discussion; it is just off the table as far as they are concerned, because of all of the reasons that have been given today, and others, but they do want to offer health insurance.

Two-thirds of small business people do now offer health insurance to their employees. The vast majority of the remainder, 90+ percent, indicate in survey after survey that we have taken that they want to offer health insurance—to their full-time employees, first, and then to their part-time employees. When asked why they are not doing it, they give a multitude of reasons, but of course at the top of that list is cost and profitability of the firm.

So, when you talk big business-small business in this arena, I think you are talking more than just a difference of degree; you are almost talking a difference in kind. I mean, the threshold questions are so stark and dramatic at this level of enterprise that it is just completely different.

Senator RIEGLE. Let me ask you this, as a follow-up. When you say about two-thirds of the small businesses do offer or provide health insurance in some form, were you referring now to your own membership, or small business generically defined?

Mr. ROUSH. It is our membership, but it turns out that that is just about the same figure across the country.

Senator RIEGLE. I am wondering if the same dynamics are at work there that I am seeing every other place; that is, that the insurance costs to employers are going through the roof, in part because of the uncompensated care of the uninsured in the country.

I am wondering, even within your population of small businesses, if you are starting to see any cross-over effect here; where the uncompansated costs of the one-third that would like to but are not able to provide insurance are shifted to the rates that the two-thirds are paying.

Mr. ROUSH. The answer to the question, as far as at the perception level, is no, our members don't believe that that is happening in the small business community, and frankly they don't believe it happens between big business and small business. They think it is a bogus argument, and they don't see any evidence to support it. They believe it is, frankly, a political argument. So, they don't believe it.

Senator RIEGLE. I take it, though, that the two-thirds who have insurance are finding their rates going up as dramatically as we see it.

Mr. ROUSH. Dramatically.

Senator RIEGLE. They don't argue that their rates are going up, but they don't necessarily attribute it to the cost of the uninsured, is that the essence of it?

Mr. ROUSH. That is right. The testimony that we have submitted outlines a relatively comprehensive proposal on our part to try to address the cost problem, which is the primary problem that we see, and it involves the insurance industry, and it involves a number of the reforms that were talked about by other people here today.

We think there needs to be more competition in the insurance industry. There are underwriting practices that need to be changed. It includes providers, doctors. The doctors need to face more competition. It includes the health insurance industry, as I have said. It includes the Government, the barriers that the Government has put in place, either through the Tax Code or things like ERISA. The State governments have put barriers and prohibitions to competition. And it includes consumers, our members and their employees, as part of what we would recommend needs to be done to address the cost problem.

It is an evolving strategy, a tentative strategy, frankly; but at this point it has come a long way from where we, as an organization, have been, even a few months ago, and, as I say, it is relatively comprehensive.

It covers a number of things that are in your working paper, as a matter of fact. I asked my staff to put a side-by-side together of our proposal with an annotation of what option of your working draft corresponds—it is just done in pen and ink right now, so I am not submitting it—and there is quite a bit of correspondence.

We would urge you to select those options in your working paper that most closely correspond to our strategy, because there are a number of them.

Senator RIEGLE. Well, we want your input, and we need to have it, and we want to have something that is going to work.

I would just say, before yielding to Senator Durenberger, that more and more the larger companies that I am hearing from—and that is why I am posing the question—are concluding that their cost structures for health care are being driven up by the cost of the uninsured. Whether they are right or wrong, there clearly is that view, and it is a very large number. That is sort of a sea change, as well.

I would think, at some point, smaller-sized businesses might in fact be coming to the same conclusion. But you are saying you are not yet hearing that from your members, and there is skepticism about that?

Mr. ROUSH. Correct.

Senator RIEGLE. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, I do want to suggest that if you haven't read Mike Roush's Statement, you do; because it is excellent. It has a whole series of what he calls "endnotes," which I thought were footnotes; but, if they are not at the bottom of the page and at the end of the page, you call them "endnotes." He has a lot of endnotes, which go with the beard, I guess. [Laughter.]

Senator DURENBERGER. I mean, it makes it an erudite Statement, or something like that.

I want to ask my question now about why we use the work place, I guess, and I will start with Dr. Hoffman, because he would rather be in Toronto than in Long Beach, to use your analogy.

I am looking at the model that you recommend, the so-called "Canadian model."

Dr. HOFFMAN. Yes.

Senator DURENBERGER. The CNHI proposal, which UAW endorses, says, "The plan would have to provide comprehensive health insurance coverage to all residents of the State." Why does it bother with health insurance if it is in effect using the Canadian model?

Dr. HOFFMAN. As I indicated to you, I think it is a uniquely American approach, in that one way is that it does build on the experiments that have existed in this country, and the Massachusetts experiment, as well as others that private-sector folks have been doing across the country, we and our counterparts in the auto industry, with some of the changes we have done with health care delivery, and it allows for States to select State health plans, and they may vary from Alabama to Michigan to Montana to Wisconsin.

Senator DURENBERGER. I am trying to ask the question: Why do we bother with health insurance, or why do we bother buying it at work? Why don't we just go to the Canadian system, where the State of Massachusetts, or California or Minnesota, can guarantee all workers a basic benefit and in effect pay the doctors and the hospitals?

Dr. HOFFMAN. I have no problem with the concept. But I think, in the current political situation, with the way health care has developed in this country as compared to the way health care was when the Canadian system developed, it is probably better to start with the approach that we have outlined, and that is this Federal-State partnership, building on existing approaches, and it may be very different from raising revenues in a State that would want to do it a different way.

It may have different orientations, and it allows for that American incentive system that has existed on the positive side. You know, we have heard the problems throughout the system, but everything is not bad; there are some good efforts.

Senator DURENBERGER. Under the ultimate of the CNHI plan, do you see the employer continuing to make contributions?

Dr. HOFFMAN. It certainly could be. In fact, a State could decide the way they want to do it would be to mandate health care coverage based on employment—they could have the Massachusetts model as a choice—and the next State would not, would have it as a Social Security approach. And they may choose three delivery systems in a State that has variations by geography, or six, or nine, and people could choose which of those would be there, and you would use fiscal intermediaries, or the State could do it themselves.

Senator DURENBERGER. I see.

Dr. HOFFMAN. So the idea is, this tent is pretty broad. I would ask everyone to reconsider joining into that, at least a debate, because what we are attempting to do is put together an approach that is severely lacking right now.

What I ask business leaders that I meet with, other than the gentlemen here, when I meet with them I say, "Where is it, in your State, that you can go and sit down and talk to the key actors in health care, and make a decision by a political action group that is there, and it will affect, and actually——

Senator DURENBERGER. Detroit. Detroit is one, I would guess.

Dr. HOFFMAN. I don't know. We would love to see it happen. It hasn't, yet.

You see, if you start talking about what is going to be spent next year, you right away talk about quality concerns, you talk about access concerns, instead of microcosms, at every table or at every business or in the physicians groups, or who is donating services. If we don't start talking about it in a unified way, I think we are going to just exacerbate the problem.

Senator DURENBERGER. All right. Thank you.

Mr. Roush?

I was going to ask all three of you to react, but the yellow light went on.

Senator RIEGLE. No, forget the yellow light. Go ahead.

Mr. ROUSH. In the explanation of that answer, from our members' perspective, I think you get a stark distinction. The gentleman talked about a "political" decision on who, and how, and how to improve. You are addressing a person who not only is a believer, himself, but who represents unapologetic believers in the market, the efficiencies of the market and how things are allocated in society.

We trust more to the anonymous allocation, of the market than we would trust to any political decision. Frankly, the populist strain of our membership, not liking big things of any sort and always feeling like they are excluded from those decisions is possibly a big reason why they don't like those kinds of political decisions.

But on a philosophic level, to make it pure, the efficiency seems to be there when you don't have those kinds of political get-togethers, deciding who and how and where things are going to be distributed in this society.

It comes back to the Senator's question, again, as to why Canada has gone to that system and why we are slow to do so. I think it is philosophy and economics.

Senator **Durenberger**. One might make the argument that it is your system that has got us in trouble; we wouldn't even be here today if it weren't for your free-market system. So I will go to the two fellows in the middle and see if they dispute that.

Mr. **Roush**. I will dispute that, but it is their turn.

Mr. **Hungate**. I think a free market sometimes needs a little help to work a little better, and there may be some places where some improvements in the market would make some progress on a lot of the other issues.

I would say that the regulation that has occurred in Massachusetts under the rate-setting processes there has not worked very well, in that Medicare opted out, and one of the big battles last year was the $50 million shortfall that the hospitals claimed for Medicare underpayment, which the State later reneged on and did not pay until sued by the hospitals.

At the same time we were having this health care access debate, the State was 2 months in arrears on Medicaid payments, so we were significantly behind in paying for other obligations. So it is not a simple solution.

Senator **Durenberger**. Before we go to Wally, I would just like to quote from your strategy for managing the cost, because it sounds so good.

The first is, "Design programs which encourage employees' providers to make medically sound and economically efficient health care decisions." Wow. You know, that is just really terrific.

Mr. **Hungate**. But it is a lot of work.

Senator **Durenberger**. Yes.

And then, "Continue to provide health care alternatives; continue to monitor utilization costs," and then you have a terrific Statement up here about "improving the quality usually decreases costs," which sort of ties into it.

I wanted to ask you the question: How much would it cost Hewlett-Packard to do that, as a percentage of the dollars that actually end up going to providers?

In other words, I presume that you are a self-insured company, and I also presume, if I can believe your Wellesley example of the insurance costs, that somebody is ripping off the City of Wellesley, and it isn't the hospitals and the doctors; I don't believe they raised their rates by 166 percent. Somebody is ripping them off. I think that is a gross exaggeration of the term; but what is your percentage cost to administer a program like yours?

Mr. **Hungate**. Our total cost of administration is somewhere below 10 percent.

Senator **Durenberger**. Below 10 percent.

Mr. **Hungate**. I can't give you a hard percentage. I know when we looked at the COBRA program, it is about 15 percent, because we have to do billing under that and a lot of things that we are not used to doing; but that is the highest within our program, where the others are below 10.

The other part of the answer, for Wellesley, is that we had a retired firefighter who needed a heart transplant, and I think he affected the ratings for 17 communities.

Senator **DURENBERGER**. Thank you.

Wally?

Mr. **MAHER**. Senator, your question regarding the tie to employment is a very good one. I never had the privilege of meeting Walter Chrysler, but I can assure you that probably the last thing on his mind when he started the company in the Twenties was the design of an HMO or a medical plan design; he wanted to build good cars and parts.

Employers got into this through the quirks of wage and price controls during World War II. Therefore, it has always puzzled me, the possessiveness that some in the business community now attach to the employment-based system.

That being said, it seems to me that a business ought to look at this from the standpoint of knowing (1) that is going to have to contribute to the support of the health system in this country, and (2) that it ought to examine all the models and choose the one that produces the less overall cost for the country and improves the competitiveness of business. If that happens to be a public/private partnership with an employer model, so be it. If it doesn't, so be it. But I don't think there should be this total wed-ness to that issue.

Regarding the market at work that Mr. Roush mentioned, I spent a day in a congressional district last month, from literally sun- up to well into the night, talking to a lot of small business people—small business people—the majority of whom I am sure were less than 10. It will be a millennium before those people will be ready to take on, voluntarily, offering health coverage to their employees. A lot of those proprietors themselves, the owners of the business, didn't offer insurance. It is beyond their mindset that they could go out and offer it to their workers.

You can have insurance reform until the cows come home, and I don't think that they will voluntarily do it. Some may, but I don't think you are going to make a big dent in that population.

Senator **DURENBERGER**. Thank you.

Senator **RIEGLE**. I am trying to model out something here in my own mind. I have had a chance, Mr. Roush, to go through your Statement since we talked earlier, and there are a lot of interesting points in it. I appreciate your Statement, and the recommendations you have made.

I want to just think aloud with all of you for a minute, sort of coming around another way and thinking about where we go from here. How do we capture this problem and solve it in an effective, fair, and sensible way?

I am trying to make sort of a grid for myself as to those things that any modern society would seem to need to have on the input side, to try to be able, with its people, to go out and have a successful performance, as a country in and of itself or in the international marketplace.

Maybe these things change from decade to decade or from century to century, but when I try to do it today in a 1990's perspective, I tend to put down on a list the following things:

I tend to say that education is a universal requirement for a nation to succeed today. You had better make sure that everybody is getting educated up to some high standard.

I put health care on that list, because I think you not only have to be a people whose brains work but whose bodies work as well. You want a healthy population.

You obviously need a measure of public safety within the society, because societies don't work perfectly.

You obviously need an external strategy, a national defense strategy, which includes military, on the one side, and economic, on the other.

And the environment. Maybe we didn't appreciate the need for a healthy environment when we were a big continental country and there weren't many of us; when the skies were clear and the water was unpolluted, and so forth. But now, the stresses and strains are such that we understand the need to pay attention to that; hence, Earth Day II.

Maybe others would add things to that list. I haven't thought long enough about it to know whether I would or not; but I think I clearly feel today that those five items have to be there. All of this within the sort of encompassing nature of our free-market, free-enterprise system.

That is the nature of the way we have come down the track—a lot of vitality and a lot of competitiveness within our system, and differences of opinion over the bargaining table—labor, management, big business, small business, public sector, private sector, a lot of good lively give and take which has given us a lot of room to innovate and do things.

But just using that as a general model, I come back around and I say, "Well, let us take the health care item." I will just give you one illustration and make my point, then I would be happy to have anybody react to it.

I went to a hospital in Flint, Michigan, recently, my home town, Hurley Hospital, where they have a very substantial neonatal unit. Senator Durenberger, a lot of the babies that come in under weight from different geographic locations are brought to this hospital, and where, if they detect a problem in a pregnancy, they were brought there. There were a very large number of under-weight babies that would weigh a pound and a half and up, but not much more than that, in this neonatal unit.

I talked to the doctors about one child, a little girl, who was then 50 days old. She came in at I think 1 pound 8 ounces. She was up to 2 pounds 3 ounces. She had really done quite well over a period of 50 days.

It was remarkable. I mean, you may or may not have done this, but it was a very powerful experience to see an infant that is essentially 2 pounds in weight. How very tiny they are. It takes high tech equipment—very advanced incubators—a very skilled and dedicated nursing staff, and so forth to keep such a child alive.

I asked how much money had been spent through the first 50 days to sustain this child, and they said about $150,000. I started counting up all the little children who were in there in the same circumstance—"One fifty, 300, 450, 600"—and this was just one room. There was an adjacent room with children in the same circumstances. I got sort of a shock treatment as to what is going on as we apply this wonderful high-tech science to children with these extraordinary difficulties and who need this help if they are going to survive.

I thought about it in a lot of different ways. I thought about the fact that we could have purchased a Harvard education for any one of these children in just getting them through the first 50 days. Now, I don't know how many of them will end up, having a chance to get a Harvard education or what it might cost 18 years from now. It might pay for a half a semester 18 years, the way inflation rates are going.

I was struck by the fact that we have some remarkable capabilities, but what is going on, and the cost dimensions of this is just one illustration. I could cite many, and you are all experts and can cite examples that you have seen, as well.

But I say to myself, "If we haven't reached the point now where we figure out how to make sure that everybody is healthy and up to speed"—not just after they get here but, presumably, sensible prenatal care and nutrition, and so forth, so you keep more of the kids out of these high-stress situations that are so difficult for everybody and so horrendously expensive, where you can prevent it and sensibly sort of avoid it on tech front end—"I don't see how the country, today, cannot figure out a health care regimen that includes everybody."

For half or more of these kids in that neonatal unit, the public is paying the bills. I mean, you and I are paying, whether we are private citizens, small business, big business, retirees; we are all footing the bill, because most of those children were in circumstances where they were on public assistance.

So, we are all paying. And this is burgeoning. In every city in America of any size, this problem is increasing; it is not decreasing. And it is not just increasing in terms of sheer cost but in the number of individuals that need to help.

Yet, here is our future. This is part of the American Family.

I don't know how we can start from any other proposition than saying that we need an encompassing strategy and system that picks up, in as sensible a form as we can, the health care needs that run across our society, from the first person in the society to the last one.

So, it seems to me, if that seems to be what a nation that is going to be successful going into the future has to say for itself right off the bat, that that would settle a lot of arguments. It also settles a lot of theological arguments.

Then you get to the mechanics. In other words, how do we rationalize the system into one that gets the wall-to-wall health protection out there to everybody in the society, but does it in the most efficient and fair fashion?

Why aren't we to the point where we decide that is the starting point? That is really what needs to happen. Is there a counter-argument that I am missing?

Senator **Durenberger**. I would just make one briefly, Mr. Chairman. It is "because I have been raised to believe in the glorification of sickness." And whether it is tech television ads that these folks talk about, in terms of glorifying medical technology, or it is the fact that "I never got paid to stay healthy, but I got paid to get sick," that is the way it has been in America. You won't find that many neonatal intensive-care beds in Europe, because they try to put the money into the womb; you know, they put it in the mom, and they don't put it there.

But we have got this deification, practically, of illness. Medicare doesn't have a wellness benefit in it, you know? It presumes that we pay old people to get sick.

We have got so much of that in our society now, which is why I admired the very brief little Statement that Mr. Hungate as in his testimony about what they are up to. But, still, they can't do much for the kinds of problems you are talking about, because those are going on all around the plants, the Hewlett-Packard plants, and the poor neighborhoods, and the low-income folks, and the schools that are broken down, and the homeless people, and all the rest of that sort of thing.

If this Nation can't identify health as something broader than what we are talking about today and integrate all of those systems—getting lead out of the gasoline so that little kids in Detroit don't have to suck up the fumes, and all the rest of it—if you put it in that larger context, we aren't going to make it, because the costs are going to kill us.

I really appreciate what I heard you say, but I think that is part of the answer to it; we can't solve it all with health insurance.

Mr. **Hungate**. If I could add to the same track, my sense is that we are working with a model of insurance that is a sickness insurance, that came about when we spent very little on health care because we couldn't do very much. Now, people claim that half of health care costs may be lifestyle-related. But we haven't changed the model of coverage.

If we really begin to think about health insurance instead of sickness insurance, then I think you are on the right track, because that is really where we need to go.

Our major change in health status has come from better drinking water, sanitation, not from health care.

Senator **Riegle**. Well, I am all for that. But on the other side, I have been visiting hospitals, and emergency rooms in the late hours of the evening. I see this whole side of our society who are outside the health care system. Their health care system is the nearest emergency room that is willing to take them.

So, they come in at all hours of the day and night with children who have fever. It is not just somebody who has five bullet holes, who got in the middle of a drug exchange here in Washington, D.C. And you see this massive influx in many, many places. You see more of it in the big cities, but that is not unique to them.

And here we are.

You wanted to make a point, Dr. Hoffman, then we will go right down the table here.

Dr. **Hoffman**. I have never heard it said better than the way you put it, but let me just put it into this context and place it back again:

The fact that we are paying through public services for the neonatal care for those children is in fact just a happenstance of this so-called "free market system." What we generally do is ignore problems totally. We don't have any location, as I said before, where we sit down and say, "What are we going to do in Michigan?" or any other State, where we are going to plan for this and organize it together. It, in fact, is a reverse argument on this so-called issue of "rationing."

You know, we have rationing in this country. It is on the basis of where you live, the color of your skin, or how much money you have in your pocket. And it is because we have not had a public decision on what care, what prevention care, what health status oriented programs should occur—all of those things cannot happen unless we join together and say, in a political sense, "This is what the system ought to look like."

You can't leave it up to Bill Hoffman, Wally Maher, even you, Senator, to make those judgments in our own little world, because too often we ignore the problems that aren't before us at the time, and we are dealing with those issues that are before us and not those that are out there.

I am sorry to say I think it is a direct result of the Reagan decade, the "me-ism," we are not worried about our fellow man and woman any longer, and it has caught up with us in the health care arena as it has caught up with us in a lot of arenas. That is how I attribute the problem.

Senator **Riegle**. Mr. Maher?

Mr. **Maher**. Senator, very quickly, on your fundamental quandary about, "Gee, aren't we there, on agreement on universal access?" it seems to me the Pepper Commission, in its goals Statement, was unanimous on that issue. Yet, when Congress then gets to appropriation and budget issues, it acts in a different way.

In Michigan, at the same time that we have a State-wide body studying access to health care, enpanelled by our Governor who is very concerned about this, contemporaneously, State government is racheting down the Medicaid and Social Service budget.

Senator **Riegle**. As we are here.

Mr. **Maher**. Absolutely. And that is the reason that we need everybody to lock arms, including the Administration, with a purpose and move forward on this issue.

It seems to me that the people in this room and in this city have the ability, since they run the biggest health programs in the country, Medicare and Medicaid, to set a model in terms of devising health plans that have maximum efficiency and really lead the way here. I mean, the Federal Government is the major player in health system delivery, and what better party than to lead the way in terms of putting it in place?

We had a start this last year in the expenditure target concept for Medicare, and if we can move forward on malpractice reform, embody that in the Federal programs, I think it would play an immeasurable role in accomplishing the vision that you have.

Senator **Riegle**. Mr. Hungate?

Mr. HUNGATE. There is universal agreement on the need for access and a lot of discussion on how to get there. I am pleased to see that there is agreement on the need for access. But how we get the pieces crafted is going to take some time and a lot of work. I am glad we are working on the process.

Mr. ROUSH. Senator, economics started out and only remains interesting as a branch of moral philosophy, and I think the answer to your original question, "Are you overlooking something?"—with the children—is that we live in a world of limited resources. If that is true, and if it is accepted, and once it is accepted, then choices have to be made on that realization.

As I say, that is where economics started, and the only place where it remains interesting is when you are dealing with moral choices. But you have to establish some base, and the base is that we live in a world of limited resources, unfortunately. And free market economies flow from that base as the most efficient and moral way to allocate those resources.

Senator RIEGLE. Yes, but let me take that a step further, because we can all look at it from the point of view of our own philosophy. And in a different time and under different circumstances, we might advance a moral argument that says, "Look, I want to help the guy across town or in the other part of the country, whether I know him or not, if he has got an urgent problem, just because that is my human philosophy."

Setting that aside for the moment, we have now gone into a new age where there is now an economic imperative that must be added to and weighed along with any moral imperative that one wants to advance. I would be prepared to advance the moral argument, myself; but let me put that to the side.

As I understand this, we all have a different vantage point on the problem; but as I try to comprehend the magnitude and the dynamics of the problem, I think the economics of the problem are now cutting against the nation.

In other words, I think we now have a problem that is of a sufficient size, and we are now to the degree of integration in 1990 in terms of how the society connects itself, and in fact that we have to fit in and survive in a world economy that is putting new burdens on us every single day, that we now have to find an economic solution to this problem. This lines up quite well with the moral imperative, if one wants to make that argument as well.

I think we now are at a point where we have got to figure out how to get everybody on the American team. The 240 million people that we have in our society need to have sufficient education and decent health and capacity, so that the society as a whole can perform well. We need to have as many fully functioning "units of production," to use a labor market term, as possible to not only provide the national achievement and income but also be in a position to provide for themselves and for their families.

There is so much going on at once. We just had a hearing this morning of the Banking Committee on how the United States' financial system should think about integrating itself into this changed world financial system that is coming at us at light speed—Europe '92. It is very difficult to even conceptualize it, because so much of what we have lived and experienced isn't terribly relevant to this enormous set of changes that have come upon us. We are caught up in old practices, old mechanics, old engineering, old ways of thinking and so forth, when we have been hurled into a new age.

I think the same thing is true here. Somehow or another, I think we have got to get over the logjam of the debate that has to do with whether or not we need a rational system that covers everybody. I think we ought to try to get ourselves to the point where we figure out how we re-do the mechanics, the system design, and the economics to make it fit the solution that we are after, so we can have a healthy country that can produce and get the job done.

Mr. ROUSH. A comment?

Senator RIEGLE. Please. Sure.

Mr. ROUSH. I agree, but I think in some senses, and I don't say this to be "smart," or anything like that——

Senator RIEGLE. I am thinking out loud, so it is not a finished thought; that is a thought in process.

Mr. ROUSH. It is just that health has been on that list of what constitutes a good society and a good life since the ancient Greeks put it on the list. So I don't think that "health" as a constituent of the good life, and what a good society should do, and what a competitive society should do is a new thing. You know, the economics, as misunderstood as that word is, the technology, the economics, the times have changed, so that we are able now to get closer to fulfilling that ancient promise of "health." But there is no way of fulfilling that promise. We are not necessarily within reach of having the ability to have good health for everybody, but we think we can see it, almost, in the distance. And it causes us to ignore how we got to this point.

Senator RIEGLE. Yes, but let me just react to that. I think we are past that point, if I may say so, respectfully. If you look at the amount of money we are spending, and the percentage of GNP, and the fact that you have 30 million-plus, depending upon the estimate, of the people out there who haven't a penny of health insurance right now, you say to yourself, "Somehow, we went hurtling through a series of developmental phases, and now we are spending a ton of money, have very uneven coverage, and a lot of people have none at all, and are in truly desperate circumstances."

So I think, starting from the Greek model, we have gone beyond a critical point where now we have got to collect ourselves and make sure every American has his or her basic needs met and can fully participate.

I think we can cover everybody for less money than we are now spending. I start with that proposition.

You have identified, Mr. Hungate, as have some of the rest of you, places where the money is leaking out of the system, where we are not getting a health benefit. The money is disappearing in the tens of billions of dollars, and we are not getting a health yield. Meanwhile, we have got walking wounded where we could get a lot of yield for probably not very much money.

Now, how we move the dollars from where they shouldn't be to where they should be is where we prove whether we are smart enough and a civilized enough society.

But if we don't define the problem right, we are likely to spend a very long time getting there, because we will be back-filling, and we will be doing it over individual bargaining tables, or it will be big business versus small business, or the States versus the Federal Government. I don't think we have time for all of that.

Mr. **Maher**. I think it is worth the observation, Senator, that the Greeks and every other country, other than the U.S. and South Africa, have addressed this problem differently than we have. That is why it is not a front-burner problem, I am assuming, in Athens as it is in Washington, DC.

Senator **Riegle**. Well, it has been a good discussion, and I appreciate all of you coming. I appreciate your patience in waiting through a long afternoon. It has been very helpful to the committee, and I thank all of you.

The committee stands in recess.

[Whereupon, at 5:25 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF C. PATRICK BABCOCK

I am C. Patrick Babcock, Director of the Michigan Department of Social Services. I applaud you for your continuing interest and leadership in the U.S. Senate on the issue of health care coverage for all Americans.

There are few issues in the human service area where there is a greater need for Federal action. I am here today to share with you some of what we are learning about this issue, and to offer our views on how best to reach the goal of health care for all.

Over the past two years, Governor Blanchard's Task Force on Access to Health Care has examined in depth how best to address this issue. The Task Force has examined the national data which indicate that about 15% of the population (approximately 37 million Americans) do not have any form of health care coverage whatsoever. The Health insurance Survey of Michigan, which was commissioned by the Task Force, indicates that in 1989 approximately 11.2% of the Michigan population under the age of 65 were uninsured.

The Task Force found that the uninsured in Michigan are a young population: 56% (532,500 individuals) were under 25. Almost 30% of the uninsured were children under the age of 18. Another 43% (329,200 individuals) were between the ages of 26 and 64.

Over one-half (53%) of uninsured persons had family incomes that were less than $15,000 in 1988. Forty-one percent were at or below the Federal poverty level, and 58% were below 200% of poverty.

A substantial. majority of the uninsured adults (66%) were found to be linked to an employer; only 2% were self-employed. The majority worked full-time and were employed in small firms that had fewer than 10 workers.

In addition to the statewide survey, the Task Force also investigated a number of policy options for the uninsured. Very early in its deliberations, the Task Force adopted the following set of principles to guide the discussion of these policy options:

- The solution should be a mix of private and public involvement and responsibility in the provision of resources to increase access.
- The uninsured should have freedom of choice of providers within one or more health plans.
- The primary focus should be on providing insurance for the uninsured at an adequate reimbursement level so as to assure access for a defined basic level of services.
- The goal should be to increase the number of consumers receiving the basic level of services.

The Task Force requested its Academic Consortium to research options that would meet these guiding principles. A number of research papers were developed and have been included in the draft final report of the Task Force. Options included employer mandates, a Canadian model and a voluntary "categorical" approach.

As co-chair of the Task Force (with Walter Maher of Chrysler Corporation), I have come to appreciate the difficulty of forging a consensus among forty Task Force members who represent but some of the interested parties in this discussion. The debate on the policy options was spirited, yet, the Task Force was able to reach consensus on the fundamental principle that health care coverage for all citizens of this state is a goal worth achieving. From that consensus has emerged a commitment to find a solution which is both politically feasible and affordable.

The Task Force has not yet approved its final report. However, can tell you that the Task Force felt that our current health care system or non-system is seriously flawed. Many members were concerned about pursuing policy options that would continue to build upon our existing "system."

After thorough discussion of the various policy options, I have concluded that a state cannot provide universal health care coverage on its own. It cannot and should not be a state-by-state solution. Simply put, a state cannot afford to place itself at a competitive disadvantage by adding requirements and business costs which do not exist in neighboring states.

The Task Force agreed that the preferred solution was at the national level. It went on to outline the basic elements of a universal health plan that would be consistent with the Task Force's guiding principles. Ideally, the plan would establish a single payer and would provide coverage to all citizens regardless of employment status. In other words, coverage should be decoupled from employment. However, the existing multiple delivery system would be maintained.

Funding for the plan should be shifted from the employment sector to the public sector. The Task Force also expressed a strong belief that the plan should contain significant cost containment measures. Initiatives to improve access and cost containment must be implemented simultaneously.

While the work of the Michigan Task Force supports the development of a universal health plan (either Federal or federal/state), the crisis faced by many of our fellow citizens requires immediate action. The task force has identified a number of interim measures that would address the needs of the more vulnerable populations and at the same time move us in the direction of a universal health plan.

Interim access initiatives would include programs for children, persons with disabilities and individuals employed in small businesses. The Task Force discussed cost containment strategies but did not adopt specific measures. Examples might include Resource-Based Relative Value Scales and hospital all-payor systems.

Allow me to offer a few comments on some of the approaches being considered in your proposal.

MAXIMIZING PRIVATE HEALTH INSURANCE COVERAGE

Because three-fourths of uninsured persons in this country are employed, or are the dependent of someone who is employed, this focus deserves first priority. Essentially, this means finding ways to cause employers, who up to now have decided not to offer health coverage, to find it in their private business interest to offer health coverage.

Our experience suggest5 this will not be easy. We now have two years experience with the Health Care Access project (HCAP), a demonstration in two Michigan sites, Genesee County (Flint) and Marquette County.

HCAP offers businesses the chance to offer health insurance at a significantly reduced cost. Through the project's "One-Third-Share Plan," HCAP will pay for one-third the actual cost of health insurance for businesses which haven't offered health coverage before. It is a significant incentive, which we believed would encourage many businesses to initiate health coverage.

We found that fewer than 15% of qualifying businesses decided to begin health coverage. virtually all businesses declining to participate cited cost as the primary reason for not participating.

Vern Smith will describe the lessons learned from HCAP in greater detail in separate testimony. However, the bottom line conclusion is that even significant incentives (such as a tax credit or a subsidy of one-third of the actual health insurance premiums) are not likely by themselves to be sufficiently powerful motivators to encourage large numbers of employers to offer employer-based health coverage.

Still, such incentives as may be possible within the tax code should be included in a comprehensive strategy. We believe such incentives to be especially important for small businesses and the self-employed.

In addition, we would welcome special authority to establish state-sponsored health insurance plans which would serve to create more affordable options for small businesses.

HEALTH BENEFIT DESIGN

We have also looked at the issue of benefit design. It has been our conclusion that health coverage should be broad and comprehensive. It makes no sense to us to cover only the basic health services, even primary and preventive care, and to leave catastrophic events uncovered.

Conversely, it makes no sense to us to cover only the catastrophic events which will occur infrequently and affect relativelY few individuals, while leaving uncovered the primary and preventive cure.

Public Sector health Coverage

After taking steps to maximize employer-based health overage, public programs must be restructured to ensure that there are no cracks in the safety net through which anyone could fall.

Again, our conclusion is that the best that could happen here is for a Federal program to be established which would offer uniform coverage and eligibility levels across all states.

Current Medicaid eligibility rules have become so complex that they are accurately described as "Byzantine." In Michigan, we now have some 28 different eligibility categories, reflecting the different situations under which Medicaid eligibility can be attained. A simplified example is shown in Chart I, which we used in considering options for the new "Healthy Start" program, which Governor Blanchard announced in his State of the state message in January. This chart illustrates that, depending on a child's age, a child will qualify for Medicaid in Michigan at 60, 100%, 133% or 185% of poverty level income levels.

Specifically, Medicaid eligibility is set at:

- 85% of poverty for infants, up to their 1st birthday (and for pregnant women regardless of age)
- 133% of poverty for children from age 1 to their 6th birthday
- 100% of poverty for children age 6 to their 7th birthday for the year beginning October 1, 1990; and, for children age 7, to their 8th birthday, for the year beginning October 1, 1991
- 60% of poverty for children up to age 18, if they are in a family deceiving AFDC benefits, or who qualify by "spending down" to this level for their own medical bills.

Medicaid eligibility needs to be simplified and kept separate from eligibility for other programs. For the most part, these are changes that need to be made at the Federal level, either by establishing a national program, or by creating options which state Medicaid programs can take advantage of at their option.

At the very least, we believe Congress should provide states the flexibility to establish Medicaid eligibility levels at 200% of the poverty level.

IMPLEMENTING UNIVERSAL HEALTH COVERAGE

In establishing a universal health care system, it is likely that we will need to move in steps and phases. There can be no question that the highest priority for health coverage is for pregnant women and for children.

There is no reason, however, that such priority should be limited to kids under age 6, for example, or age 10, or 11 or 16. It is imperative that eligibility options for Medicaid be extended to age 18, and to at least 185% of the poverty level, at the earliest possible date.

When Governor Blanchard decides, as he has, to commit scarce Michigan dollars from a very tight budget for Healthy Start, to assure health coverage for all children in this state up to age 10 in families with incomes under 200% of the poverty level, that should indicate very clearly the urgency which we in Michigan are feeling toward resolving this issue.

COST CONTAINMENT AND ACCESS

In the Task Force discussions, there has been a strong sentiment that cost containment features must be an integral part of any proposal. It may be that the solution to the access problem is to be found within the solution to the cost problem for health cure.

As I have thought about this, it seems that there may be another way to look at it. Perhaps the solution to the cost problem in fact lies within the solution to the access problem. If we can assure access to all citizens of this country, and structure the financing and delivery systems to achieve this goal, we may very well have established the mechanism to control the enormous costs of our health care system as well.

There are sufficient dollars now within the system to provide universal access if. we can redirect those dollars now allocated to uncompensated care and excess administrative costs. Our task is to find how to do it. We are more than willing to do our part. We look forward to working with you to make the changes at the Federal level which can most effectively provide health coverage for all Americans.

PREPARED STATEMENT OF DAVID W. BENFER

I am David W. Benfer, Executive Vice President of Henry Ford Hospital and Group Vice President of the Henry Ford Health System, Detroit, Michigan.

On behalf of the Henry Ford Health System, I would like to thank you for convening these hearings. Access to health care in Southeastern Michigan and the growing numbers of uninsured individuals is at a crisis stage, and we need your help.

The individuals presenting testimony today are telling you from a personal perspective why this country needs a national health policy. I've been asked to comment from an institutional perspective on the problems and the elements of reform you are considering.

The most important determinants for decency and vitality of a city, a state, or a nation are the health and education of its people. In health care, we are witnessing a dangerous deterioration. The current problems are evidence of a major transition in health care which require attention as we seek the broader, more permanent solutions.

If I had to choose only one of a range of issues to focus on, it would be the lack of a comprehensive health care financing policy and our diminished ability to shift costs for low income patients to our paying patients.

At Henry Ford Hospital, we currently finance 14 million dollars per year in uncompensated care, and will absorb an additional 16 million dollars in Medicaid underpayment and bad debts. This financial burden has increased more than 40% over the past three years.

Over the past three years, we have seen operating margins for hospitals in Michigan deteriorate to zero. The number of uninsured patients is increasing, and the absolute cost for providing care is increasing (labor, equipment, facilities). At the same time, Medicare, Medicaid and third-party payors have turned to fixed payments (about 85% of our revenue base is fixed payments, leaving only about 15% of the base for cost-shifting). The result is a growing need for the charity care subsidy and a dramatically reduced capacity to finance it.

Our health care system has always had significant subsidies available for charity care and for excess capacity. Now, cost containment payment mechanisms designed to squeeze out excess capacity are also squeezing out the charity care subsidy. This past year, Congress moved to protect the subsidy for unused capacity in rural hospitals (granted rate party with urban hospitals) Direct help for urban hospitals with regard to charity care is also needed.

Currently, the major public sources of financing for the non-paying patient are the indigent care adjuster (Medicaid) at the state level and the Indirect Medical Education payment (Medicare) at the Federal level. Both target extra payments to urban hospitals serving the poor.

Both payments are under attack this year. Governor Blanchard has asked the Legislature to reduce Medicaid payments about $65 million overall, and identifies indigent care for an approximate $18.1 million cut. President Bush is asking Congress to cut the Indirect Medical Education payments by nearly 50%. Without benefit of more detail on these proposals, we believe the impact on the Henry Ford Health System will easily approach $10 million in 1990–91.

The old system is broken, and the nation needs a new alternative. You are in the process of proposing a series of changes aimed at establishing a comprehensive national health policy. Your underlying assumption is that our poorest people will definitely need the support and assistance of our Federal and state governments and I agree with you. Health care is a basic right. Unfortunately, people without health insurance do not have an organized constituency advocating on their behalf. Therefore, it is appropriate that Congress advocate on behalf of this group of citizens.

Turning now to the elements of reform you are considering, we would support mandated health insurance for all employees, and have specifically expressed support in the past for Senator Kennedy's employer mandated legislation. The combination of mandates and support for low-income employed individuals, either through a tax incentive program for small employers, or through a partial subsidy program for companies at risk, are logical approaches to the employed population. It also makes sense to mandate the insurance industry develop risk sharing pools for small employers to assure affordability.

I believe it is appropriate for government to standardize benefits and mandate basic services for primary care and inpatient hospitalization. The catastrophic costs could be pooled at a state or national level, and separate financing for catastrophic costs could be arranged.

In terms of cost containment mechanisms, these services should be provided through a managed care environment. Case management has demonstrated significant utilization reduction of high cost services and elimination of many unnecessary costs. This approach is proving more successful than cost controls and expenditure limits previously imposed through Federal regulation. In addition, case management by responsible providers does not carry the negative incentives that we are seeing from past and present payment systems. The current approach allows cost concerns to interfere with access and quality. Quality and access make huge demands on cost.

There is currently very little opportunity, outside the managed care system, to have a planned balance among all three objectives.

All individuals should be covered by minimum benefits financed either by the employer or the government or through tax incentives. Government help should be provided to our poorest population first.

Expansion of the Medicaid Program by providing universal access for all individuals who are less than 100% of the poverty level and providing graduating subsidies for those individuals under 200% of the poverty level makes sense.

You have asked for a reaction to the question of Federal versus state initiatives. The more we look at the issue, the more cautious we are becoming about a centralized Federal program for everyone, along the lines of Medicare.

Health care is a local industry, meeting local needs and priorities. What is emerging in our internal and external discussions in Michigan is the concept of a regional health system, like the Ford System, that is big enough to accept risk and responsibility for defined population (in a geographic region) but small enough to focus on local priorities and be accountable to the local community. There are a number of activities we have undertaken in the way of trying to assess local needs and develop productive directions for health care services in our community.

This past year, Henry Ford Health System has initiated an Urban Task Force composed of area health officials, health system executives, businesses, medical society, urban league, and a number of concerned Henry Ford Hospital physicians and staff.

This Task Force is developing a model which not only manages health costs, but also addresses the root causes of deteriorating health status.

The model is for a defined geographic service area, and would provide health coverage for all, through either an employer mandate or public subsidy.

Participation in this program would require enrollment in a managed health care plan. The plan design incorporates input from individuals living in the community, in order to establish the concept of the individual's role in determining their own health status.

The population initially addressed lives in the four contiguous zip codes around Henry Ford Hospital. We have some initial health status information and are investigating the possibility of measuring the impact of improved access in terms of health status indicators, such as infant mortality, hypertension and diabetes.

In addition, we are surveying our Emergency Room admissions to try to better understand source of payment, family size, and family income for these patients. Approximately half our total admissions come from the E.R., and about 1/7th of total E.R. visits result in admission.

Through our Task Force discussions, we have concluded that the sociologic components which are contributing to the deteriorating health status should be addressed through:

1. Educational programs in the community (K-12)
2. Establishment of preventive health and lifestyle modification programs
3. Community collaboration for crime prevention and violence reduction on the neighborhood level
4. The establishment of job retraining programs to facilitate employment
5. The establishment of housing rehabilitation service to stabilize the housing stock
6. Nutritional support programs for those in need, regardless of age
7. Day care for working families
8. Accessible health services

As Reed Tuckson, M.D., Health Commissioner of the District of Columbia, has described it, health is the intersection where all social forces converge.

In addition, the Henry Ford Health System is making strides to organize services among our affiliate hospitals to meet access and cost concerns. We are increasing our managed care (HAP) enrollment, and strengthening vertical and horizontal organization of services.

We remain committed to the low income population of Detroit, and are finding ways to broaden our financial and philanthropic base in the suburbs to subsidize charity care.

It is all of our responsibility to make the necessary changes in health care delivery systems to ensure:

1. Accessibility to quality health care as a right
2. Health service is available in every geographical area
3. Reimbursement systems recognize care for the uninsured
4. Incentives are established which require participation in managed care programs for the publicly financed recipient
5. New models of delivery must be established in areas where high unemployment and limited access to health services exist. (Models which address the root causes of deteriorating health status and the deterioration of our community need to be tried.)
6. Health care is delivered on a regional basis by vertically integrated systems organized to provide cost effective care with emphasis on continuously improving quality.

Senator, while this may seem ambitious, if we are to promote dignity and vitality of our communities, we must begin by better understanding the problems and promoting practical initiatives.

Thank you for the opportunity to present these views for consideration.

URBAN HEALTH INITIATIVE TASK FORCE MEMBERSHIP LIST

N. Charles Anderson, Detroit Urban League
Gary Barnes, Henry Ford Health System
Archie Bedell, M.D., Henry Ford Medical Group
David W. Benfer, Henry Ford Hospital (Chair)
Michael Boyle, D.O., Henry Ford Medical Group
James Bridges, M.D., Henry Ford Medical Group
David Brooks, Metro Medical Group
Darlene Burgess, Henry Ford Health System
Robert Carlson, Greater Detroit Area Chamber of Commerce
Robert Chapman, M.D., Henry Ford Medical Group
Jack L. Clark, M.D., Henry Ford Medical Group
Janiki Darity, Henry Ford Hospital
Vernice Davis-Anthony, Wayne County, Health and Community Services
Margaret Dimond, Henry Ford Hospital
Karen Gaffke, Office of U.S. Senator Don Riegle
George Gaines, Detroit Health Department
Dennis Gibson, Metropolitan Detroit Youth Foundation
Symond Gottlieb, Greater Detroit Area Health Council
Donald Hirt, Henry Ford Health System
Janet Jones, Greater Detroit Area Health Council
Douglas Klegon, Ph.D., Henry Ford Health System
David Leach, M.D., Henry Ford Medical Group
Mary Logan, M.D., Henry Ford Medical Group
Kathleen Maslanka, Wayne County Medical Society
Patricia McCarthy, Henry Ford Health System
Susan Mozena, Detroit Receiving Hosp. & University Health Center
David Nerenz, Ph.D., Henry Ford Health System
Richard Nowak, M.D., Henry Ford Medical Group
Emanuel Rivers, M.D., Henry Ford Medical Group
Wilmer Rutt, M.D., Henry Ford Medical Group
Robert Sanders, Blue Cross/Blue Shield of Michigan
Richard Smith, M.D., Henry Ford Medical Group
P. Whitney Spaulding, Sisters of Mercy Health Corporation
Edward Thomas, Detroit Receiving Hosp. & University Health Center
Marianne Udow, Blue Cross/Blue Shield of Michigan
Stephen Velick, Henry Ford Medical Group
Glenn Wesselmann, St. John Hospital and Medical Center

PREPARED STATEMENT OF SENATOR LLOYD BENTSEN

Finding an affordable way to provide access to health care for our 63 million uninsured Americans is a difficult challenge. Due to the complexity of the issue and the cost to both the private and public sectors, I believe that we will need to take incremental steps to get there.

Certainly, keeping health care affordable by taking steps to slow the spiral of rising costs goes hand in hand with improving access to services. All parties who pay for health care services—business, insurers, the Federal and State governments, and individuals—have a large stake in keeping health care costs within bounds. In 1965, health care consumed 5.9% of the GNP; that figure had reached 11.1% by 1987. Much of this is increase is due to the fact that each year we provide more health care services to more people, but prices for medical services also grow faster than other prices—averaging about 8.3 percent a year during the 1980s, compared with about 5.3 percent for prices of other items. So I commend Senator Riegle for holding this hearing to focus on the issue of controlling health care costs.

Tomorrow, Senator Riegle, Senator Chafee and I, joined by a number of other members of the Committee on Finance, will introduce legislation that will take steps to improve access to health care services for children. The bill would expand the Medicaid program to cover all children under age 19, with family incomes up to 100 percent of the Federal poverty line.

In developing this legislation, we have consulted with representatives of the National Governors Association, and have provided that new benefits be offered on an optional basis, so that states that wish to provide home visitor, home and community based services and outreach services for pregnant women and children can do so with the Federal Government sharing a portion of the cost.

In addition, we been sensitive to the financial concerns of the States and therefore would phase-in the new coverage beginning with the youngest children, expanding a year at a time, until all children in families with incomes below the Federal poverty line were covered by the year 2002. States would have the option to do more, by covering children with family incomes as high as 185 percent of the Federal poverty line.

This proposal would help one of our most vulnerable populations gain access to health care services and get off to a healthy start in life. Clearly, there is much more to be done to improve access to health care services for the uninsured, even just for pregnant women and children. A recent report by the Columbia University National Center for Children in Poverty indicates that in 1987, nearly one in four children under the age of six lived in poverty. Half these children are in families with one working parent, yet they tend to suffer from inadequate health care. While we took important steps last year to improve Medicaid coverage for these youngest children, gaps in coverage remain. And I look forward to exploring, along with my colleagues, possible approaches for addressing the broader problem of the uninsured.

We have an impressive array of witnesses this afternoon who have had hands on experience in dealing with the problems of access to care and health care costs. I particularly look forward to hearing from Governor Dukakis, who has undertaken a bold plan to extend health care coverage to all citizens of Massachusetts. Implementation of this plan has not been without controversy, and I would appreciate any insights and recommendations he may have for us as we confront these difficult issues.

PREPARED STATEMENT OF DAVID AND ARLENE DILLOWAY

My name is David Dilloway. I am here to talk about my wife, Arlene, and our experience with the health care system.

I previously testified at the hearing of the Senate Finance Subcommittee on the Uninsured. At that time, I shared that Arlene was uninsurable. We tried public and private health insurance programs, however, no one would accept her. The private insurance companies told us that she wasn't eligible for benefits because she had a pre-existing condition, diabetes. The Social Security Administration told us that she didn't qualify for Social Security Disability Insurance and Medicare benefits because she hadn't worked 5 out of the last 10 years, a mandatory eligibility requirement. In addition, she didn't qualify Supplemental Security Income and Medicaid because I made too much money and had too many assets. I believe that Arlene's condition prematurely deteriorated because of the her lack of insured status and are ability to get needed health care.

Since I last spoke, Arlene's physical condition has worsened to the point that she has permanent kidney failure and needs dialysis twice a week. Because of this permanent disabling condition, she now qualifies for Medicare through Social Security. In addition, we have found a supplemental insurance plan to help cover the Medicare deductibles. Even though we are receiving some insurance coverage now, Arlene and I continue to go into debt in order to pay for her necessary medical treatment.

Currently, I pay $30.00 in Medicare premiums, $60.00 in a Blue Cross Blue Shield (BCBS) supplement and $180.00 for prescription drugs. A total of $270 per month. The BCBS supplement covers the 20% of Arlene's dialysis treatment that Medicare doesn't pick up. With Medicare, there is a large deductible. BCBS is the stopgap, but we are paying dearly for it.

As for me, I still have no health care coverage at all. I work for a construction company that pays a salary, but doesn't provide health insurance benefits. I could receive private insurance but I just can't afford to pay the $130.00 per month that it would cost. I am not eligible for public assistance because my income is too high and I haven't been disabled for 12 consecutive months. I am very fearful of what would happen to me and Arlene if I ever got seriously ill or injured.

As for our financial situation, we haven't been able to pay off our debts. Right now, our financial statement shows that I am paying more than I am bringing home. We still have four court judgments against me for my failure to pay the hospitals and doctors to which we owe money and that's just the tip of the iceberg. In addition to these court judgments, I have had my bank account garnisheed. The government was going to take my income tax return this year, but they couldn't because I owed $2,000. I owe money to five different hospitals. My situation today is just as bad or worse than the last time I testified.

I feel like I am falling through the cracks of the system. Senator Riegle, if your plan guarantees the availability of health insurance at a reasonable cost, comparable to private insurance, than I am all for it. If it is offered on a sliding fee scale that's O.K. People like Arlene, who have pre-existing conditions need health insurance to be available and affordable. What really makes me mad is when I know there are programs available to other people, but I can't get them for us. If I hadn't looked for insurance benefits for Arlene before she was sick well then shame on me. I did, however, and I couldn't find anything. I feel so angry when I am standing in a line at the drug store and I watch people ahead of me paying 50 cents for a prescription drug that cost $80.00. I would like for us to be eligible for that program, but at the present time, it's just not available to us.

Medicaid falls short of being helpful to those in need. It will never work for us because it has an income and an asset limit. When we applied, they literally told us that we had to get rid of everything we owned to qualify; not that we have anything to get rid of. In fact, once you are on the program the rules are so unrealistic. For instance, the program mandates that you must only spend $110.00 a month for shelter. Now you tell me where I can get any kind of decent housing for that amount? The public assistance programs need to be expanded as you described in your plan.

I am willing to pay for insurance at a reasonable rate. I currently make about $20,000 per year, and I could probably afford a family insurance program. The most ideal situation would be to have my employer pay for my insurance as part of my wages.

The last point I would like to make is that most people don't realize that what happened to me could happen to them. I am here today to talk about my problems and enlighten those idealistic thinkers. I know that it's too late to change Arlene's situation, but I hope that I've made a difference for someone else. Thank you for allowing me to testify.

PREPARED STATEMENT OF GOVERNOR D. DIPRETE

Thank you, Mr. Chairman. As Governor of the State of Rhode Island, I am very honored to have this opportunity to testify before the Subcommittee on Health for Families and the Uninsured.

In recent years, the health-care system across the country has approached a state of financial emergency. Rhode Island is no exception. Consumers, employers, health plans and hospitals have all felt the impact. Health costs continue to rise at an unacceptable rate. And as costs have risen, the number of uninsured Rhode Islanders has continued to grow at an alarming rate as well.

Here are the problems we face:

(1) The total cost of health care in Rhode Island has grown from $2 billion in 1987 to $2.6 billion in 1990. This is an increase of 30 percent in three years.

(2) Many Rhode Island businesses are facing double-digit increases in their health insurance costs. Companies are paying much more in health benefits at a time when New England is experiencing an economic slowdown.

(3) Some employers are asking workers to pay a higher share of the growing cost of health insurance. Such requests are being vigorously resisted by labor, and tensions between management and labor are growing. In addition, consumer-advocate groups have called for a freeze on health insurance rates.

(4) The State government itself is paying twice as much for employee health benefits today than it did five years ago. The prospects are that these costs will double again over the next four years.

(5) One of Rhode Island's three major health plans was granted a 43 percent rate increase this year. Despite this huge increase, the health plan is still in financial difficulty.

(6) The percentage of uninsured in Rhode Island grew from 3 percent in 1975 to 8 percent in 1987. Between 1987 and this year, the rate has increased by 50 percent more, and is now 12 percent.

(7) Almost all of our is private hospitals have been struggling financially over the last three years. They've had to contend with minimal increases in Medicare payments, double-digit wage increases in a tight labor market, and rising amounts of free care and bad debt. Last year my administration had no choice but to provide $3 million in emergency relief to the hospitals. If we had not acted, one inner-city hospital might have closed its emergency room, which serves 40,000 people a year.

Public and private leaders in Rhode Island have been taking numerous steps to stabilize the situation, and progress has been made. However, it is apparent that states alone cannot adequately address the crisis in health costs. The Federal government, which is the dominant mayor in the health system, needs to take the preeminent leadership role.

In Rhode Island, State government has used its regulatory powers throughout the 80s to restrain the growth of hospital expenditures and insurance rates. Last year, we provided some cash to the hospitals at their time of greatest need, and it now appears that the hospitals will not need additional aid. This year, we are tackling the problem of uninsured medical patients.

Our uninsured rate of 12 percent is low compared to the estimated national average of 17 percent. But the amount of free care and bad debt absorbed by the hospitals has roughly doubled since 1982, and the amount exceeded $30 million a year in 1989. Our inner-city hospitals carry a disproportionate share of the burden.

More than 80 percent of the uninsured in Rhode Island are employed, or dependents of working parents. And the employer is a very small firm with 25 or fewer employees. The number of uninsured seems to be growing primarily because ever-higher health insurance rates are pricing companies out of the market.

An important reason for the premium increases is the growing list of health benefits that the state requires all carriers to offer. Our legislature has mandated—with all good intentions, and frequently with my support—such benefits as prenatal and pediatric services, chiropractic services, and in-vitro fertilization. However, it is estimated that mandated benefits add as much as 25 percent to the cost of health care in Rhode Island.

The hospitals have been particularly hard-hit by the growing number of uninsured patients. This is because many physicians and dentists do not accept the uninsured. As a result, many end up seeking treatment in the high-cost emergency rooms of the hospitals.

In response, I have introduced state legislation this year permitting insurers to offer a basic insurance package. Carriers will be allowed to market plans with fewer benefits, at less cost, to the uninsured.

Our hope is that this pilot program will succeed in reducing the ranks of the uninsured, while lowering the levels of free care and bad debt that the hospitals must bear. This legislation was introduced at the recommendation of a steering committee I appointed. This committee is also evaluating the feasibility of a freeze on insurance rates, or a provision strictly limiting growth in such rates. And the committee is studying whether to strengthen the power of attorney law in instances where patients do not wish extraordinary measures to be used to prolong their lives.

It is encouraging that, whereas total health costs in Rhode Island have risen by 30 percent between 1987 and 1990, hospital costs have grown by less than 22 percent during this period. This is concrete evidence that health costs can be slowed.

State government has played a lead role in curtailing hospital costs. Briefly, here's how we control expenditures:

Each year, the state, the insurance industry and the hospitals agree on a percentage increase in operating budgets that will be permitted for all hospitals as a group.

Individual hospitals negotiate increases that are greater or lesser than the overall cap.

In addition, each hospital must apply for a certificate of need authorizing any major expenditure. Certificates are needed for major new programs coming on to the operating budget as well as major capital expenditures.

We in Rhode Island are hopeful that the worst is now behind us. However, a small state such as Rhode Island can do only so much to conquer one of the most ominous domestic problems we face in America. States need leadership and direction from the Federal Government, which is the dominant market force because of Medicare and Medicaid.

As you continue with your deliberations, keep in mind that Rhode Island—a compact state that has a large and diverse population—is a perfect setting for pilot programs that can be evaluated for use as national models. We in the State government are ready and willing to assist the Federal Government in providing the desired level of medical care, at an affordable price, to all Americans.

Prepared Statement of Governor Michael S. Dukakis

Thank you, Mr. Chairman, Senator Kennedy, and members of the Committee.

The United States soon will be spending $2 billion a day for health care. Yet, nearly 40 million Americans had no health insurance at all, and another 60 million are underinsured.

We are spending more on health care than any other nation in the world, and yet millions of our fell citizens go to bed at night not knowing whether they will be able to pay their bills if one of their children gets sick.

During the presidential campaign, I often spoke about my father, a family doctor who priced medicine in a simpler time when a doctor's first question to a patient was "where does it hurt?" not "how will you pay?" Today, far too many Americans, most of them in working families, lid in fear of the first question because they can't answer the second.

Basic health security should be the right of every American.

And I'm proud to say that in my own State we are committed to providing basic and affordable health care for all of our citizens.

After some rocky beginnings, we are on track and on schedule. In fact, by the end of this year, we will be covering over 100,000 previously uninsured or uninsurable citizens.

The first phase of our health security act is the commonwealth program, which is paid for principally with State dollars. It's designed for three categories of people: disabled adults who are working; severely disabled children; and welfare recipients who leave the welfare rolls for jobs that do not now provide health insurance. More than 17,000 persons have been served by commonwealth since it began.

In May of 1989, we began the Centercare program which provides primary health care services to inner city residents through participating community health centers. more than 5,000 individuals now have recess to these services.

Last September, we required all full-time college students and graduate students—and we have 400,000 of them—to demonstrate either that they have health insurance through their parents or guardians or else purchase a plan from the institution they attend. We discovered that about 50,000 of those students had no health coverage of any kind.

We worked with college administrators and insurers to help develop affordable basic health insurance packages for students.

And we were able to develop a variety of plans at an average cost of less than $300 per policy. In fact, there are some graduate students in Massachusetts right now who have the best health insurance bargain around.

This summer, we will begin the next major phase of the universal health care all Massachusetts employers with more than five employees will pay $16.80 per employee per year to pride health insurance for uninsured unemployed workers. We estimate that at any one time some 30,000 unemployed workers and their families will be covered by the plan.

Finally, we ape phasing in a series of pilot proram8 that we hope will provide small businesses with affordable health insurance for their employees.

Eighty-five percent of our small businesses already provide health insurance to their workers, and most of the rest want to. But they can't if they have to pay a premium on top of a premium.

Last week, I visited a small business that is taking advantage of one of these phase-in programs, one marketed by the John Hancock Mutual Life Insurance Company.

Chris Anslono, the young owner of the Lynn carburetor and auto service, has three employees, and he had just about given up hope that he would ever be able to afford health insurance for them and for himself. Now, he can provide his family and the families of his employees with basic health security.

By 1992 we hope that all of our employers with six or more employees will be able to meet the law's mandate at a price they can afford.

Because beginning that year, all such businesses must provide at least $1,680 worth of health insurance to each of its employees. If they don't, then they must contribute that much to a special State trust fund and the commonwealth will provide the insurance.

After two years, I believe the Massachusetts' experience provides some important lessons for a national health plan.

First, it makes sense to use the present employer-based system as the foundation for any national plan. It's the simplest, fairest and most equitable way to extend coverage to workers and their families.

Second, the uninsured are not a homogeneous group. there are young and old, working and unemployed, students, disabled working adults and children. As we have discovered in my State, we will need a variety of approaches.

Third, we need reforms in our insurance system that prohibit the denial of coverage because of a previous condition and the charging of higher rates to small businesses.

I am proud of the progress we have made in Massachusetts. But we are not alone. An increasing number of governors, frustrated by lack of action in Washington, are moving ahead on their own. Washington, Hawaii, California, New York, Ohio, and Michigan are among those who have acted to insure basic health care coverage to their citizens or have comprehensive proposals under active consideration. But as much as states relish their roles as national laboratories, 50 health care experiments won't give us the kind of national guarantees that our citizens deserve.

Moreover, we at the state level have a huge stake in finding ways to bring health care costs under control. without some reasonable control over costs, we will never sieve the goal of basic health security that Harry Truman proudly proclaimed in 1949.

Booth Gardner, the Governor of Washington, who will assume the chairmanship of NGA this summer, has already made it clear that health care will be the top issue during his tenure. A health care subcommittee of the NGA has already been formed to look at the twin issues of health care access and cost containment. It is my hope that, under his leadership, the nation's governors can work with Congress and the administration to make this the year that puts us on the road to universal health care.

We did it on welfare reform in 1988. And we can do it again.

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE DEPARTMENT
STATE HOUSE • BOSTON 02133

MICHAEL S. DUKAKIS
GOVERNOR

UNIVERSAL HEALTH CARE UPDATE

April 18, 1990

In April 1988 Governor Michael S. Dukakis signed into law the Health Security Act commonly known as universal health care. This law ensures that **all** Massachusetts residents--including the 600,000 people who are uninsured--will have access to affordable health care by 1992. Despite reports to the contrary, the law is intact and implementation by the Department of Medical Security is on schedule. As this report describes, important steps have been taken to lay the foundation for universal health care. We expect that by the end of this year over 100,000 people will have been provided with medical coverage.

COMMONHEALTH

The CommonHealth program was implemented in July 1988 as the first phase of universal health care. Administered by the Department of Public Welfare, CommonHealth provides medical coverage to three groups: people who leave welfare to go to work, disabled children, and disabled adults who want to go to work.

Over **17,000 individuals** have enrolled in CommonHealth to date, and the enrollment, especially of disabled children and adults, continues to grow.

STUDENT HEALTH INSURANCE

The Health Security Act required that all college and university students enrolled full to three-quarters time be covered by health insurance by September 1989. This provision was implemented on schedule with few problems. All college students in Massachusetts must now either purchase health insurance through their institution or demonstrate that they are covered by a comparable plan.

We estimate that **about 50,000 students who did not have insurance prior to enactment are now covered.** We also estimate that this coverage will result in **up to $15 million in savings in the hospital uncompensated care pool.**

CENTERCARE

In May 1989, the Department of Medical Security began a program called CenterCare to provide primary health coverage to uninsured people using participating community health centers. The Department pays the health centers a monthly rate tied to their enrollment.

Currently, over **5,400 people** are enrolled in CenterCare in **23 health centers** across the state.

PHASE-IN INITIATIVES

Under the Health Security Act of 1988, the Department of Medical Security is required to establish phase-in initiatives to test different approaches to providing health insurance to the uninsured. The Department's goal is to test plans which are affordable and attractive to consumers, and at the same time cost-effective for businesses and the state. These programs are designed to gauge price sensitivity in the small business sector.

By the end of 1990, we expect to **insure approximately 10,000 people through the phase-ins.** The Department is contracting with HMOs and insurance companies in two rounds for FY'90 phase-ins. In the **first round,** we have **signed five contracts for comprehensive insurance plans, targeted primarily to businesses with less than 25 employees.** For the **second round,** we have just **issued an RFP asking for proposals for insurance plans with premiums at roughly $1,680** per contract, the level of contribution required of employers in 1992. We have received five responses to this solicitation and we expect additional contracts to be effective this summer. The Department has placed **$11 million in a trust fund** to support these contracts, in FY'90 by subsidizing premiums, sharing risk with the insurers, and supporting administrative and development costs.

UNEMPLOYED WORKERS

Beginning July 1, 1990, unemployed workers who are receiving unemployment compensation will be eligible for health insurance coverage through the Department. We expect that roughly 325,000 workers will claim unemployment compensation from the Department of Employment and Training (DET) this year. A recent DET survey indicated that 40 percent of the claimants at any one time are without health insurance.

The planning and development for this program are on schedule. The Department will contract with one or more vendors to carry out all aspects of this program--both administration and insurance coverage. **A Request for Proposals was issued in January.** The program will be funded by revenue generated by employer contributions to the Unemployment Health Insurance trust fund; beginning in January 1990, all Massachusetts employers with more than six workers are required to pay up to $16.80 per employee into the trust fund. We estimate that these contributions will **generate $34 million** in 1990.

HEALTH CARE COVERAGE FOR ET GRADUATES

An increasing number of graduates from our employment and training (ET) program for welfare recipients -- over 92% in the first six months of this fiscal year -- are finding jobs which provide health care coverage. This can be attributed, in part, to performance-based contracting and aggressive efforts by our Department of Public Welfare and DET to place people only in jobs which have employer-based coverage. It also is an indicator that employers, faced with a tight labor market and future implementation of universal health care, increasingly are choosing to provide health care coverage to their employees.

HOSPITAL UNCOMPENSATED CARE POOL

The uncompensated care pool was created in 1985 to serve two purposes: to provide greater access to hospital care for uninsured and underinsured individuals, and to distribute equitably across all hospitals the financial burden of serving these individuals. The pool is financed through an assessment on hospital bills paid by private insurers. Chapter 23 made two changes in the uncompensated care pool: it limited the private sector liability for pool charges--for example, to $318.5 million in FY'89--and it directed the Department of manage the pool beginning in October 1988.

In managing the pool, the Department has followed two strategies. First we have **improved access to free care** for people with limited incomes by expanding the eligibility limits to 200 percent of the poverty level for full free care and offering partial free care to individuals with incomes between 200 and 400 percent of the poverty level. Second, we have **implemented rigorous standards to govern the maximum amount of bad debt that hospitals can charge to the pool.** We estimate that the new standards will result in approximately $40 million in savings to the pool, and thus to both the state and private businesses.

TAX CREDITS

Beginning in January 1990, certain employers who begin to offer health insurance to their employees can claim a tax credit for two years based on the employer's health insurance premium costs. The amount of the tax credit is **twenty percent of the employer's premium costs in the first year and ten percent in the second year.** To be eligible for the tax credit, an employer must have 50 or fewer employees, not have contributed to their employees' health insurance premiums for three years and have contributed at least fifty percent of the costs of the employee coverage.

MANDATED STUDIES

One of the key elements of Chapter 23 is the directive to conduct a series of studies designed to gather systematic information on which to base policies and new programs. One mandated study, an **analysis of the small business insurance market**, is being released this month. This analysis, conducted by the Department of Medical Security and its Small Business Advisory Board, describes the problems small businesses face in purchasing health insurance for their employees, and highlights the need for **insurance reform** in order to establish a universal health care program. To follow up on this report, the Advisory Board and business organizations across the state are **sponsoring public hearings** in March to solicit ideas from business people and insurers about changing the small business insurance market.

A second mandated study, **a survey of uninsured and underinsured Massachusetts residents,** will provide a detailed picture of their demographics, employment, insurance, health status and access to health care. This study is currently underway and will be completed by April 1990.

CONSTITUENCY DEVELOPMENT

Since the Health Security Act breaks new ground, it is important for the Department to work closely with a wide range of constituencies in implementing universal health care. During our first year of operation, we established and met regularly with **two advisory boards**: the small business advisory board and the uninsured advisory board. We also established and met with **regional workgroups across the state composed of representatives from a variety of businesses. Despite the newness of the Department, we also responded** to an average of 75 calls a week from consumers and business people **looking for information and assistance with their health and insurance problems.**

PREPARED STATEMENT OF SOLOMON HOCHBAUM

My name is Solomon Hochbaum. I am the Chairman of the Department of Emergency Medicine at Sinai Hospital in Detroit.

Expansion of the Medicaid program for people below the Federal poverty level and the creation of a new public program for those at or above the poverty level but without private health insurance coverage would be helpful. With respect thereto, two items are significant and must be taken into account:

(1) Coverage of both programs should provide for 100% of the cost of service and,

(2) It needs to be recognized that, in urban areas in particular, these two population groups seek a significant amount of their healthcare from hospitals—primarily through the institutions' emergency service programs.

The reason for that phenomenon is two-fold:

(1) Too many private practice physicians have left the urban area, and those that are left are becoming more selective in their clientele, and

(2) Hospitals' emergency services are mandated to provide services to whomever presents themselves.

The Sinai Hospital experience is only one of several examples of a frustrated urban hospital in the City of Detroit. Sinai Hospital witnesses approximately 30,000 E.R. patient visits per year, and growing. These patients account for about a third of the hospital's total inpatient admissions. 58.9% of those inpatient admissions live in the City of Detroit, 22.9% live in Oakland County, 9.4% live in Wayne County, and 8.8% originate from other geographic locations. Of those patient admissions, Sinai Hospital operations loses millions of dollars a year.

Hospital emergency rooms are becoming flooded with patients who walk in or are brought to the facility by car. They have to be seen, and, for defensive reasons, all too often excessive service is provided. More and more, the EMS service is re-routed to another hospital—and, consequently, trauma cases are on the increase in most urban areas.

Under-funding by Medicare and Medicaid will cause the closure of hospital trauma service as we have known it for the past several years. It will not support the urban area's EMS transportation system. And that will happen this year.

In 1990, urban hospitals will just not have the financial reserves that resulted from historical cost shifting to make up such losses. Certainly, Sinai Hospital does not now. Nor can Sinai Hospital provide the level of charitable care that it has in the past.

We do not disagree that the healthcare system is in need of reorganization. In fact, such work needs to be speeded up. Until that effort is accomplished, and no matter what the outcome is, the current healthcare system cannot survive continued Medicare and Medicaid underfunding in the name of cost containment.

Cost containment cannot continue as a Federal and state effort characterized by "just deciding to pay less." That policy will result in the governments guaranteed hospital bankruptcy act of 1990.

PREPARED STATEMENT OF WILLIAM HOFFMAN

Mr. Chairman, my name is William Hoffman. I am Director of the Social Security Department of the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW). I appear before you today on behalf of the one million active and 500,000 retired members of the UAW and their families.

The UAW appreciates the opportunity to present its views on the problems of the American health care system including narrowing access to services, threats to the quality of service and continuing cost inflation. The collective bargaining agreements negotiated by the UAW with the major automobile, aerospace, and agricultural implement companies and a variety of other public and private employers provide health insurance benefits to workers, retirees and their families. These programs, as well as the jobs of the workers covered by them, are threatened by the onrushing increases in the cost of health care. We welcome the opportunity to join our efforts with those of other Americans who seek real solutions to these problems and who look forward to establishing a national health security program.

Throughout the 40 year period ending around 1980, the number of Americans with health insurance protection continued to grow. The establishment of Medicare and Medicaid in the 1960s relieved both the insurance industry and the medical profession of a burden that neither could acknowledge or manage successfully. Leaders of both groups then confidently assured the American public that voluntary health insurance would eventually reach the rest of the population. There was room for all of us under its umbrella. That umbrella would shelter the millions of Americans who live from paycheck to paycheck from the otherwise devastating costs of paying for personal health care services at the time of illness.

In fact, not only did the numbers of insured grow over the 40 year period, but protection was becoming more comprehensive. Health insurance expanded to cover needs that it had previously neglected, such as mental health services, prenatal care, convalescent care, and dental services. While the insurance industry and medical community were working to assure access to health care, a third partner, private sector business, also accepted the proposition that the public interest required a transfer of the economic risks of illness from workers to employers. It was understood that, in a way uniquely American, the private sector of the economy was taking on this role so that government would not.

If it had not been obvious before, however, by 1980 it became evident that a voluntary approach would never finish the job. By then, the umbrella had begun to unravel. For the first time since 1940, the numbers of Americans with health insurance protection began to fall. Employers, almost apologetically at first, became uneasy about the increasing costs of sponsoring employee health care plans. Soon, they were looking for ways to reduce those costs. The more aggressive cost cutters, particularly at small firms, if not restrained by a collective bargaining agreement with a union, simply ceased to sponsor employee health care benefits. As inflation further ratcheted up costs, more employers dropped out. In some instances, the choice open to workers was brutally simple; keep jobs and phase out health insurance or phase out jobs and keep insurance (while jobs last). Even when workers chose jobs, they had no assurance their jobs would not also go the way of their vanished insurance.

Less desperate employers have resorted to a nearly endless array of less drastic cost cutting techniques including, by way of illustration, the following:

- reducing or eliminating specific benefits such as prescription drug, dental, vision care, or mental health benefits;
- adding or increasing deductibles and/or copays for basic health insurance and/or major medical benefits;
- reintroducing or increasing periodic worker contributions for health insurance, especially with respect to coverage for a spouse and dependent children;
- offering employees, who might have the opportunity for coverage as a dependent spouse under another employer's health plan, a cash bounty or some other enhancement of employment benefits, for declining employee health care coverage;
- reducing or discontinuing retiree/dependent health care benefits before age 65 and Medicare complementary coverage after age 65;
- introducing coverage restrictions and benefit limitations such as lengthening the period of employment required of a new hire to qualify for health insurance or refusing to pay benefits for medical conditions existing at the time coverage begins;
- abandoning insured health care plans for self-insured (either self-administered or third party administered) health care programs;
- more careful administration of plan provisions including coordination of benefits, verifying the number and identity of an employee's dependents and reviewing the medical necessity of a procedure reported on a claim form;
- utilization review and control techniques designed to reduce or discourage unnecessary hospital admissions, days of hospital confinement when no services are performed or when there is no medical justification for keeping a patient, performance of unnecessary or even harmful surgery, administering useless tests and the like; or
- introducing alternate delivery systems including health maintenance organizations (HMOs), preferred provider organizations (PPOs), exclusive provider arrangements, and dental capitation plans.

Because the UAW represents so many different kinds of workers in establishments large and small, in manufacturing and non-manufacturing units, at both public and private sector workplaces, we have had first hand experience with almost every conceivable approach to reducing health care costs. We know that these cost cutting tools act on the health care system in a variety of ways.

In theory, everyone accepts the objective of reducing waste and inefficiency in the health care system, eliminating the performance of services that do nothing for a patient's health, and encouraging the development of high quality, cost effective alternate delivery systems. Not all cost cutting efforts, however, are so benign. Some of them seek to shift costs to other employers. Many attempt to turn back the clock by shedding risks assumed earlier and exposing workers—who still, in overwhelming numbers, live from paycheck to paycheck—to an increasing share of the burden exacted by galloping cost inflation in the health care system.

Almost all such cost shifting forays are accompanied by affirmations of dedication to purchasing only high quality health care services. In fact, they are too frequently only cost driven; concerns about quality being merely an afterthought to put a better face on a previously arrived at determination to reduce benefits. In our collectively bargained contracts we have insisted on quality assurance mechanisms and appropriateness of care monitoring.

The need for fundamental reform of our health care system is becoming more urgent daily. Narrowing access to health services, inflation in the health care sector at a rate that is a multiple of two or three times the rate of inflation in the rest of the economy, and unevenness in the quality of care appear to be growing worse. The private sector, however, appears to have run out of credible "solutions" to this set of complex and interrelated problems. In the view of the UAW, the entire U.S. health care system needs reform and redirection.

The evidence of declining access to health care is inescapable. Despite our immense resources, far too many Americans lack access to even minimal health care services. Today, 37 million Americans have no health insurance coverage, an increase of 40 percent since 1980. Twenty-seven percent of the population—more than one person in four—is without health insurance coverage for at least part of the year. And millions more have inadequate coverage. In Michigan, it is estimated that nearly one million persons, approximately 10.3 percent of the population are without any health insurance coverage, including more than 300,000 children who have limited access to care.

Nationally, one-third of the uninsured are children. Two million of the uninsured are chronically ill and cannot obtain health care protection.

It is particularly disturbing to note that about three-quarters of those without health insurance are working men and women and their dependents. Although most employers provide their workers with health care protection, a growing number do not.

Retired workers have increasingly been threatened by reductions in or outright cancellation of their employer-sponsored health insurance coverage. Today, it is fashionable for employers to justify these cutbacks based on the prospective changes in accounting rules proposed by the Financial Accounting Standards Board (FASB) for post-retirement health insurance. In fact, employer efforts to cut back on retiree health care obligations predate the current FASB exposure draft by many years. The UAW has consistently resisted such efforts at the bargaining table, and since 1980 has been involved in more than 40 separate lawsuits seeking to prevent reduction or cancellation of health insurance for thousands of retired members and their families.

The decline in employer-sponsored health coverage has been accompanied by painful cutbacks in Medicaid, which was suppose to guarantee that the poor would have access to decent health care. Only 40 percent of the nonalderly population living in poverty qualifies for Medicaid today, however, compared to 65 percent in 1973. Medicaid now serves less than half of all poor children annually.

Medicare, the Federal health care program for elderly and disabled individuals, has also been eroded. The Part A deductible has increased steadily from $40 in 1966 when the program was established to $592 currently. Part B premiums have risen from $3.00 in 1966 to a current level of $28.60. As a result of these changes, many Medicare beneficiaries now pay out-of-pocket a higher percentage of disposable income for health care than would have been the case before enactment of Medicare. At the same time, Medicare still fails to cover many needed services, such as long term care, mental health, dental care, and prescription drugs.

Black Americans and other racial minorities continue to suffer markedly higher rates of death and disease than whites. The infant mortality rate in this nation is one of the highest of all industrial nations, while the death rate among non-white babies in the United States is 70 percent greater than for white babies.

There has been a chronic shortage of doctors in rural areas and inner-city neighborhoods. At the same time, dollars are wasted constructing redundant hospital beds and duplicating expensive "state-of-the-art" equipment in affluent suburban areas, where more doctors than are needed work as highly paid specialists.

The UAW believes that it is simply unacceptable for a nation, consistently a world leader in the advance of modern medicine, to allow so many of its citizens to be denied access to adequate health care services. Too often, individuals are forced to postpone or do without needed medical care because limited family income must be used for food, housing, or other basic needs. A 1986 study by the Department of Health and Human Services showed that the uninsured population used only 64 percent as many physician services as the insured. Even more shocking, nearly one in five uninsured pregnant women do not receive prenatal care during the first trimester of pregnancy.

When millions of Americans are denied access to adequate health care, the consequences are tragic, but not surprising. Restricted access shortens life expectancy, perpetuates chronic and debilitating illnesses, increases infant mortality, and generates untold pain and suffering. Ironically, lack of health insurance coverage ultimately increases the cost of individual treatment for persons who are forced to rely on hospitals (particularly public hospital emergency rooms) for medical treatment, instead of receiving preventive care and other types of more cost effective, early treatment for disabling conditions.

Restrictions on access to health care can only grow worse as the United States continues to face a systemic problem of constantly escalating health care costs. Health care expenditures amounted to $559 billion in 1989, approaching 12 percent of GNP. This amounted to $2,200 for every man, woman, and child in the country. The United States spends a greater percentage of GNP on health care than any other country. Canada, for example, spends only about 8.5 percent of its GNP on health care, Japan 6.7 percent, and Great Britain 6.2 percent. But when we measure ourselves against others, by indices such as infant mortality rates and life expectancy, we fall behind many other industrialized countries. Clearly, we are not getting our money's worth in health care.

Throughout the past three decades, the medical care component of the consumer price index has risen faster than its other components, straining household incomes, corporate balance sheets, and governmental budgets. Expenditures by the Federal and state governments for Medicare and Medicaid have continued to grow, consuming scarce resources which might justifiably have gone to meet other competing social needs. Similarly, payments by employers for health care have been increasing dramatically. Recently, we have seen cost increases of more than 50 percent in some of our negotiated health plans, while 15 percent cost increase projections are common.

In the face of inflation, many employers, identifying the culprit as excessive consumer demand, "solve" the problem by cutting hack on employee health insurance coverage in ways we described earlier. Unfortunately, the cutbacks do not attack the root causes of health care inflation, provider driven over-utilization and the prevailing fee-for-service system for reimbursing providers.

Health care is a unique commodity. The health care system is provider driven. Decisions by the consumer—that is the patient—have minimal impact on system costs when compared to decisions and practices of providers—that is doctors, hospitals, drug producers, medical equipment suppliers, insurance carriers, and a variety of medical entrepreneurs.

One of the byproducts of employer efforts to shift costs by reducing or terminating employee health insurance is an increased burden on the remainder of the employer community that finds itself indirectly subsidizing persons without health insurance or who have inadequate coverage. For the most part, uninsured persons wind up being treated at the "expense" of hospitals and other health care providers. In fact, the cost of providing this "uncompensated care"—estimated to be about $10 billion per year—is not fully absorbed by providers. Instead, it is passed on to other private payers, mostly to unions and employers, who are providing health care protection.

Employer efforts to cut back on health insurance have become a central issue in recent collective bargaining negotiations. The lengthy strikes by the Mineworkers against Pittston, and by CWA and IBEW against the telephone companies were caused by disputes over rising health care costs. Health care costs continue to be a significant obstacle to successful resolution of collectively bargained contracts and promise to be a major issue in the upcoming negotiations between the UAW and the Big Three automobile companies later this year. Even when workers successfully resist cutbacks in health care benefits, continuing escalation in costs means less money available for wages and other benefits. Thus, both employers and workers are harmed by excessive increases in the cost of health care.

The skyrocketing cost of health care adversely affects the international competitiveness of many businesses, and threatens the job security of millions of Americans. In Canada, for example, employer health care costs are approximately one-half those in the United States; in Japan about one-third. That kind of disparity is seen as an incentive by multinational corporations to transfer more production and plant investment outside this country.

Escalating health care costs also adversely affect the competitiveness of older, long established companies compared to newer employers. There are two major reasons for this. Older companies tend to have a higher ratio of retired workers than newer competitors. Thus, the older companies must bear the additional cost of paying for health insurance coverage for their retirees. In addition, the average age of the active workforce often is higher in older companies than in newer employers. Since health care costs tend to rise with age, this also places an additional burden on older companies.

The UAW believes that employers should not have to compete on the basis of their health care costs. There should be a "level playing field," with all employers sharing equally in the costs of providing a basic level of health care protection to all Americans. All employers currently pay the same contribution (i.e. the same percentage of wages) to Social Security in order to provide a basic level of retirement income to workers. The same principle should be applied to the financing of health insurance coverage for workers and their families.

Despite our enormous and rapidly growing expenditures, the quality of health care received by Americans is shockingly poor. It is estimated that 25 percent of U.S. health care expenditures go towards wasteful or inappropriate procedures. This kind of spending approaches $125 billion—money which might be better directed towards opening access for the uninsured and improving protection for those who are insured.

A report recently released by the National Leadership Commission on Health Care underscores concerns over quality of care as follows:

- 5-25 percent of all patients admitted to hospitals have quality of care problems;
- 10-35 percent of hospital admissions are inappropriate;
- on-fourth of all patients who died in the hospital were found to have been misdiagnosed by physicians;
- 50 percent of all prospective complications and 35 percent of all surgical deaths were found preventable;
- when monitored, physicians decreased their use of lab testing by 47 percent.

It is estimated that one-fourth of all lab tests are unnecessary. Half of the one million caesarean sections performed in the United States last year were unnecessary. Many other expensive procedures, such as coronary bypasses, arterial balloon operations, and upper GI examinations, are performed on persons for whom they have questionable value or for whom they are entirely unjustified. And there is a growing literature cataloguing significant variations in medical practice between different communities.

A major contributor to poor quality health care service is the fee-for-service system of reimbursing providers, which creates incentives for providers to order wasteful and unnecessary procedure. In addition, because we have developed such a multitude of public and private insurance programs, with no unitary source of payment, it has been extraordinarily difficult to establish effective, reliable, and accepted mechanisms to define, monitor and evaluate the quality of health care offered by different providers.

Mr. Chairman, the UAW believes that this combination of difficult and interrelated problems must be addressed through the enactment of a comprehensive, universal national health insurance plan. Every industrialized nation, with the exception of the United States and South Africa, has some form of universal, national health security program. Clearly this is not a utopian vision. Neither is it a goal attainable only at the sacrifice of our cherished personal freedoms and liberties. When the ideological smokescreens are stripped away, we know that individuals in Canada, Great Britain, Sweden, West Germany, Italy, France, and other free societies are guaranteed basic health care protection by law. We believe American citizens should have similar protection as a basic social right.

The UAW has represented workers in Canada for many years, and has come to admire and respect their national health care program. The Canadian system, which is based on a federal-provincial partnership, provides comprehensive health insurance coverage to all citizens in a cost-effective manner.

The UAW strongly supports the national health security program developed by the Committee for National Health Insurance (CNHI), a citizens' group comprised of trade unionists, liberal activists, physicians and academics. The CNHI proposal, known as the Health Security Partnership, is modeled on the Canadian health care system. It embraces three principal objectives:

- Improving access to health care serve;
- Containing health care costs; and
- Strengthening and maintaining the quality of health care.

Under the Health Security Partnership proposal, each state would be required to establish a state health care plan. This plan would have to provide comprehensive health insurance coverage to all residents of the state. It would also have to meet certain national standards relating to cost containment and quality assurance. In addition to setting certain national standards, the Federal Government would assist the states in financing their health care plans.

By utilizing a national-state partnership, the Health Security Partnership proposal recognizes that health care is basically a local service. This means that priorities, patterns of care, and consumer preferences need to be adapted to differing conditions in different localities. In addition, any national health care program must be able to work well with the rich variety of health care systems that have become established in recent years. Under the proposal, state and local governments would have critical roles to play with respect to rate setting, cost containment, and health care planning. Each state would retain the freedom to design their own enrollment mechanisms, patterns of funding, payment and budgeting programs and priorities. The Federal government would establish national benefits standards and cost containment targets and would help provide financial assistance to the states to enable them to implement their programs.

The major elements of the Health Security Partnership proposal include the following:

1. Universal coverage for all U.S. residents.
2. State administration within Federal guidelines with Federal financial support for state enrollment efforts.
3. Development of national and state health budgets and effective cost containment programs based on state selected prospective payment systems.
4. Benefits for all necessary physician, hospital, prescription drug, and related services.
5. Preventive and rehabilitation care.
6. Continuing evaluation and improvement in the quality of services.
7. Incentives for improved organization of personal health services evolving into integrated patterns of care.
8. Reduced complexity and expenditures for administrative costs.
9. Participation by consumers, providers, and health care employees in policy and program development and implementation.
10. Opportunity for private sector involvement (both insurer and provider organizations) in administration of program.

As you know, Mr. Chairman, the UAW has for years been in the forefront of the struggle for a national health insurance program. We remain committed to that battle and are confident that it will be won. We are encouraged by the fact that employers too are coming finally to an understanding that only a national health care program can deal effectively with the health care crisis. We welcome the efforts of employers such as ATT, Bethlehem Steel, Chrysler, and Ford on behalf of fundamental health care reforms.

Mr. Chairman, the UAW applauds your leadership in holding these hearings. We appreciate your efforts for a more equitable and effective health care system for all Americans. We look forward to working with you on behalf of our shared objectives.

PREPARED STATEMENT OF ROBERT W. HUNGATE

I'm Robert W. Hungate, Government Affairs/Healthcare Manager for Hewlett Packard Company. Hewlett Packard just celebrated its 50th anniversary last year, directly employs 95,000 people, two thirds of whom are in the United States and had 1989 revenues of $12 billion. Half of those revenues came from outside the United States, half from within making us the twelfth largest United States exporter in 1988. Fiscal Year 1989 Hewlett Packard spent $152 million in providing healthcare benefits to our United States employees past and present and their dependents.

As part of my Hewlett Packard role I serve as co-chair of the Healthcare Subcommittee of the National Association of Manufacturers (NAM) and on the board of the Washington Business Group on Health (WBGH). Although the views I express are Hewlett Packard's I don't expect either NAM or WBGH will find them inconsistent with their views.

Earlier this month my local newspaper (Wellesley, Massachusetts) had this headline "No Easy Avenues for Rocketing Health Insurance." I am not here to dispute that claim. Hewlett Packard has worked hard since the mid-70s in assuring that we, our employees and their dependents, get good value from the money spent on health care. We're far from finishing the task. The article went on to say:

> "The town's costs have risen 166.9 percent since July 1, 1987. The town, like the state, is finding that health insurance costs are ballooning and fast becoming a local "budget buster." Totaling $1,036,100 in Fiscal Year 1987 (FY87), estimated health insurance costs to the town in FY91 are $2,765.000. Those increases, averaging more than $700,000 a year, have eaten up all the extra money allowed to the town under annual Proposition 2/1-2. That means every year's tax increase pays exclusively for the rising costs of an item that consumes about six percent of the town's budget."

I don't need to tell you about constrained resources. Global competition has certainly had its impact on Hewlett Packard. Our managerial and innovative talents are constantly pressed to gain more from what we do.

My comments today proceed from agreement with the recommendation of the Pepper Commission that the employment based system for providing health benefits to people will continue, will expand, and be improved. The employer/employee political arena provides a largely self correcting system, a true strength of democratic systems. Employers who must compete for employees—and we face serious future shortages as we pay for the shortcomings in our educational system, cannot arbitrarily withdraw benefits from people. The job of a benefit manager in a corporation is not far different from that of an elected representative. "What have you done for me lately" comes from both the president on cost issues and from complaints to the president by employees. Balancing these pressures in a corporation replicates the process between Congress and Medicare beneficiaries. An unfortunate consequence of much of the cost-containment work by both the public and private sectors is that it has caused cost shifting not real management. Many managed care initiatives are exceptions to that generalization but there are no measurement systems to assess their quality.

My remarks today do not offer a quick fix. Hewlett Packard has implemented many fixes, each has revealed what had to be done next. Our strategy for managing this cost is to:

- Design programs which encourage employees/providers to make medically-sound and economically-efficient healthcare decisions.
- Continue to provide healthcare alternatives.
- Continue to monitor utilization and costs.

I should make it very clear that the motivation of our employees is a more critical factor for business success than our ability to reduce healthcare cost. Effective management of healthcare costs necessitates continuous improvement in techniques as the knowledge base available changes. What we did two years ago may no longer be appropriate next year. A formal voluntary second opinion program was eliminated as Hewlett Packard shifted to voluntary precertification which was in turn replaced by required precertification, unless you wish to pay a $350 penalty. Plan design changes limiting coverage for some services have been introduced when it seemed the dollars could be better spent on other services.

Employees need health, measurable improvement in health status, not healthcare. Employees may feel deprived if for efficacious reasons our medical advisors decide not to pay for gastric freezing or radial keratotomy. We must defend these decisions with valid information and retain employee motivation. Our continuous improvement of the management of this cost involves the following tactics, each of which is directed somehow at deriving value for our employees.

- Continue to consolidate HMOs—negotiate discounts based on experience or demographics of top 10
- Evaluate and expand mental health PPO network
- Consider plan changes for mental health
- Consider selective contracting for additional high cost procedures. (Currently done for heart transplants)
- Evaluate and expand hospital PPO contracting in high volume areas, using data analysis systems. (Currently PPOs exist in the San Francisco Bay Area, San Diego, and Roseville, California; and Colorado Springs, Colorado,)
- Evaluate patterns of care through analysis involving broad based data
- Do selective contracting for outpatient procedures
- Consider modified experience rating for premiums
- Consider adding doctor and hospital data to a telephone based employee accessed information system

- Further evaluate alternative premium structures for the Hewlett Packard Plan and HMOs

We believe the continuous attention we've given this issue has kept Hewlett Packard and our employees cost about 30% lower than others we have surveyed. About one half of our United States employees are now in HMOs, 70% in New England.

Let me now move from Hewlett Packard's immediate actions to some thoughts about elements to consider for the future.

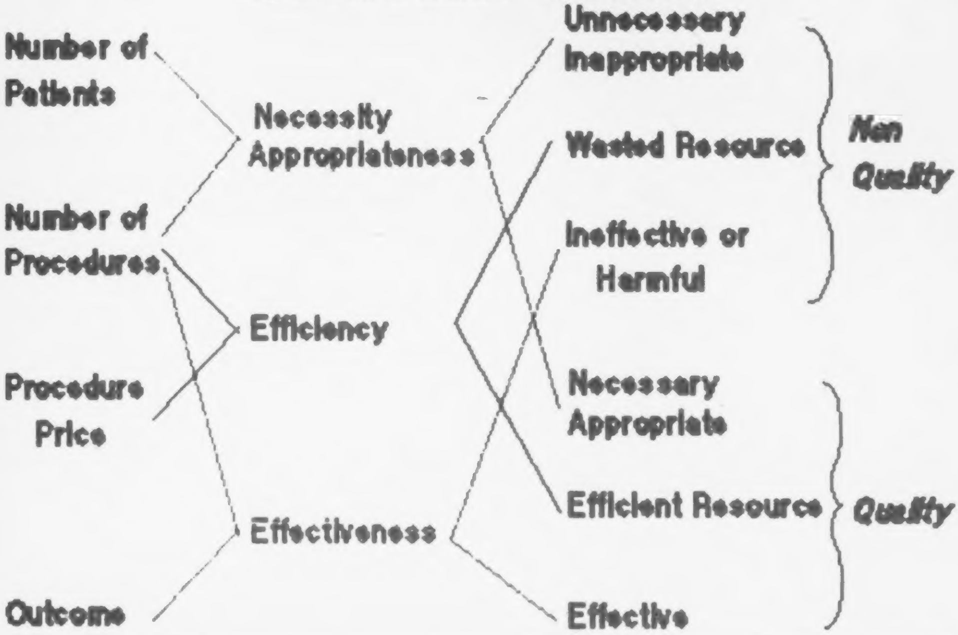
In talking about cost management it is first essential to understand what must be managed. In comparing the United States system to others, I conclude that three primary areas are adding cost without adding appropriate value. The three are Malpractice, Administrative Costs, and Inappropriate Uses of Technology. My sense is each may represent 1% of GNP, a sum worth working on!

Administrative expense for the Canadian system has been calculated to be 8% of its total while the United States is at 18%. The 10% of the health care cost yields the 1% of GNP. Similarly the threat malpractice has is a clear contributor to defensive medicine and excess utilitization of procedures. If 10% of healthcare is defensive then there's another 1% of GNP.

We should not be surprised by healthcare cost inflation. We have a cost reimbursement system—the same one that yields $600 hammers in defense procurement. We have insulated patients from costs and fueled their expectations of being cured by broadcasting the marvels of modern technology. Given our national mindset for action, "Don't just sit there—do something!;" it is no surprise that treatment patterns are more aggressive here than in other countries. Not only that, we provide tax incentives to insulate the individual from costs if his/her employer pays the bill. We've generated as part of this a public expectation that if you spend enough you'll get the very best care. Individual expectations are critical to effective healthcare cost management. Gaining an understanding that less may be better is a major part of our common challenge.

HCFA research on several procedures has demonstrated an inverse correlation between cost and quality. Hewlett Packard's experience in things it does is that improving quality usually decreases cost. Avoiding mistakes is far less expensive than fixing them and improves quality. I've formed the following diagram in describing the cost/quality relationship.

QUALITY/COST EQUATION



This diagram in fact describes what must be managed in order to contain costs. We must understand what should be provided medically, how it can be done efficiently, and how we know who gets good results. To be effective in improvement we must know which procedures work how well for which patients and for which physicians. It is only useful to know that before the procedure is done. Learning later and denying payment only shifts the cost to someone else. The place where control is exercised is when the physician or the patient decide what medical step to take in preventing, diagnosing, or treating a medical condition. To be politically stable the control system must be satisfying to both patient and physician. Before an "unnecessary" medical treatment becomes economically unnecessary both parties will need to agree. An Hewlett Packard employee who believes his/her headache justifies a CT scan will be more satisfied with the physician who prescribes it than the one who doesn't. To manage this benefit against the cost informations about quality, which is not now available to patients, is needed. That information and its credibility is a critical part of cost management. The outcome/effectiveness initiative shows promise in this regard but only if it works in terms that affect the patient/physician interface.

Since the patient choice is important here a payment on his/her part is essential to his/her understanding of the reason for and value of the additional procedure. Without a cost to the patient for the CT Scan for the headache the treating physician is forced to withhold and is placed in conflict with the patient. Instead it should be a cooperative relationship involving joint need/risk/cost relationships. With many attributing one half of current health care costs to lifestyle, we have to improve the feedback system. It will never work simply at the level of premium payment.

In order to manage costs one possible solution would be to separate healthcare into four major categories: Primary Care, Chronic Disease Management, Diagnostic Services, Major Episodic Management. Current models attempt to manage these different problems under a single global umbrella. Conditions to improve quality of result and manage use of resource, my definition of managed care, are best achieved by establishing quality measures around each of them.

We have made a great deal of noise about health cost. It's time we really understood returns for that cost: i.e. health status change. Without rigorous measures of health status, the only way we can truly assess quality, we will be unable to manage costs. The separation into categories that I propose may be essential to establishing measures of quality.

Primary care would be best measured if we used a beginning and ending health status questionnaire to judge quality instead of number of visits. The four-page SF-36 originally developed under the Rand Insurance work and now gaining broader distribution through a private vendor could be a very useful way to measure beginning and ending period health status. Access to primary care is our current most serious system problem. Establishing annual contracts with nominal visit charges and quality measurement would significantly enhance the attraction for providing primary care.

Chronic disease management is a more complex form of primary care, frequently done by a specialist. Again capitation rates, competitively set, risk adjusted and quality measured with beginning and ending health status, may be an area that needs further investigation. Providing employees information on the quality of the results gained by treating physicians or organizations is pivotal to their agreement to utilize the best value services. Business needs and can foster information development and dissemination, but cannot do it alone.

Diagnostic service such as exercise electrocardiograms, CT scans or MRIs would be best managed with fixed reimbursement fee schedules, high patient co-payment and published physician fee schedules. Individuals have different risk tolerances and testing is where many utilization differences show up. Setting high co-payment with the population that can afford this is the best way to set up good appropriateness decision making involving both patients and physicians. Co-payments and deductibles have functioned so far only as a deterrent to care and a cost shift. With information that gave them meaning they would help improve the system.

Lastly major episodes such as heart transplants, hip replacements or coronary bypass surgery should be managed as cases with risk adjusted all inclusive payment systems. Any hospitalization should fall in this category. Establishment of global fee systems for major events would require linking Parts A and B of Medicare and identifying centers of excellence. Patients will be drawn to the most efficient, highest quality locations by an informed population. Leadership works. Getting best results visible makes it very difficult for others to continue providing inferior results.

Hewlett Packard and the Congress have a common challenge in assuring their constituencies receive high quality/cost effective healthcare. Our beneficiaries' perception will be the reality of how well we accomplish that. Good information, well presented, not about costs but about outcomes—results—is our best means of managing the system.

In thinking about expansion of access to underserved populations cost management principles must be observed. That requires attention to incentives for the individual, the care providers and financial sponsors, be they government or employer. When we say access do we mean the same insulation from costs of the healthcare system that has fueled our current system? I think not. I think attention to the demographics to the populations to be addressed, attention to primary and chronic care first, careful thinking on the cost management challenge, and attention to the need for true protection from financial disaster for the individual, the care provider, and the sponsor will be essential to establishing the political base that will be necessary for improvement on the access front. Because the high cost have restricted the continued expansion of coverage, this must be addressed. The two most critical are malpractice costs and the associated defensive medicine. Public information about quality of outcome by the provider may be the best ultimate manager of improved outcomes. The second critical arena is the small business market where both coverage definition and underwriting practice need significant change.

Hewlett Packard looks forward to continued discussion with you on this issue.

PREPARED STATEMENT OF SENATOR EDWARD M. KENNEDY

This is the second in a series of hearings on universal health care conducted by the Senate Committee on Labor and Human Resources and by the Senate Finance Subcommittee on the Health of Families and the Uninsured. These hearings grow out of the joint efforts of members of a bipartisan, bicommittee work group that has held more than twenty meetings over the last ten months.

It is essential for our two committees to work closely on this issue, because we face an unprecedented and worsening crisis in our health care system.

Today, the number of Americans without any health insurance at all, either public or private, has reached a 37 million. A recent Census Bureau report found that during a 28 month period, 63 million Americans were uninsured for substantial amounts of time. Today, virtually no American family can say with confidence that it is more than one paycheck, one job change, one employer decision, or one illness away from losing its health insurance protection.

According to the Reagan Administration, 60 million Americans with insurance coverage would find their insurance inadequate in the event of serious illness. Half of all the Americans hounded by collection agencies today are in financial trouble because of unpaid medical bills.

The consequences of being uninsured or inadequately insured go far beyond the devastating economic impact of a costly illness. Fifteen million American families every year go without needed health care because they cannot afford it. Here in the nation's capital, forty percent of the people admitted to hospitals would not be as seriously ill if they had not postponed care until hospitalization was unavoidable. Across the nation two-thirds of the uninsured Americans with symptoms as serious as black-outs, unexplained bleeding, or chest pains do not make a timely visit to a physician.

The growing number of uninsured and underinsured Americans, combined with the twin epidemics of drugs and AIDS, is driving hospitals and other health care institutions to the brink of collapse. In New York City, the average wait in emergency rooms is three days before a patient can be admitted to the hospital. In Los Angeles, more than half the private hospitals have dropped out of the trauma care network that provides emergency services for the most seriously injured patients, because they can no longer afford to care for those who are uninsured.

In virtually every state in the country, patients are backed up in emergency rooms because of a lack of hospital beds. Forty per cent of the nation's hospitals fail to meet health and safety standards. Whether a patient is rich or poor, insured or uninsured, these conditions are putting lives needlessly at risk.

One of the most troubling aspects of the problem is the impact on children. Every child in America deserves a healthy start in life. But too many fail to get it because their parents can't afford it and society won't provide it. One in every five children in America today—12 million children in all—have no health insurance coverage.

Two out of every three pregnant women who are uninsured do not get the low cost, effective prenatal care that their babies need. Eighteen other industrial nations have lower infant mortality rates than the United States. Forty percent of our children do not even receive basic childhood vaccines.

We are paying more money than ever for health care—and getting less care than ever. The United States spends more than any other country on health care. We spend forty percent more per capita than Canada, ninety percent more per capita than West Germany, and more than twice as much as Japan. As American firms struggle to compete in world markets, health care has become a flash point in labor negotiations. Business and labor alike are demanding a solution to the crisis.

The states cannot do the job alone—although many of them are trying. Hawaii has had a working program in place for fifteen years. Massachusetts enacted a universal health care plan in 1988, and Governor Dukakis will testify today about its achievements.

What we need, however, is a national solution, and I urge this Committee to give its highest priority to this issue.

In my mind, the general outlines of a solution to this crisis are fairly straightforward. We already have a mixed public-private health insurance system in this country under which most working people get insurance through their employer and many of those who cannot get employment-based coverage receive insurance through the public Medicare or Medicaid programs.

Rather than start again from scratch, I believe the most practical approach is to extend that mixed system so that every American is covered. It has been more than half a century since we required employers to pay a minimum wage, to contribute to the Social Security retirement system, to purchase workman's compensation insurance, and to participate in the unemployment compensation system. In 1990, the time is long overdue to require all employers to either provide health insurance to their workers or contribute to a public program to provide coverage. At the same time, no one should be denied health insurance because they are unemployed. Just as employers need to take responsibility for workers, there should be a public responsibility to offer coverage to all who are ineligible for coverage on the job, with premiums tied to ability to pay.

This kind of a public-private partnership is a fair, American solution to the fundamental need to assure every one of our people the basic right to health care. And as part of a comprehensive solution, we need to include ways to get medical costs under control.

Universal health care itself will dramatically reduce the burden on those businesses that are already paying for care—as much as 30 percent in some cases. But universal access is not a total solution to the cost problem. Another measure that is clearly essential is insurance reform, to give small businesses a fairer price and to focus insurance companies on competing to control costs rather than competing to insure only the healthiest individuals. We can and must weed unnecessary, costly procedures out of the system. Some studies have shown that as many as 40 percent of certain surgical procedures are clearly unnecessary. We need to maintain the investment in medical research that can not only cure dread diseases but reduce the cost of caring for the victims. And we need to explore other creative methods of getting health care costs under control.

The members of our Labor-Finance working group are committed to introducing comprehensive legislation this spring that will deal with the problems of both access and cost. I hope that the Committees and the full Senate will take up this legislation as soon as possible. Our neglect of this issue is an embarrassment to Congress and the country. Ignoring the problem is no solution. It is time to make affordable health care a basic right for all Americans.

Prepared Statement of Bob Lathrop

My name is Bob Lathrop, and I am the Political and Legislative Director for the Michigan State Council of the Service Employees international Union. I want to thank Senator Riegle and the other members of the Subcommittee on Health for Families and the Uninsured for this opportunity to present our views.

I'm pleased to have this chance to share with the Subcommittee the experience and perspective of SEIU on one of the historically key areas of union advocacy on behalf of our members—health insurance coverage.

The labor movement has played a major role in developing the private insurance network that today covers some 65 percent of all Americans. But today, skyrocketing health care costs and declining access are fast destroying our employment-based insurance system.

It's common knowledge that two-thirds of the 37 million Americans without insurance are full-time workers or dependents of these workers. Less well-known are the additional 40 to 50 million working Americans and their families who are finding medical benefits increasingly unaffordable. Runaway health care cost inflation is a prime culprit in this unraveling of employment-based health coverage.

While more Americans go without routine coverage, troubling questions about the quality of medical care we get for our considerable investment are being raised. According to the National Leadership Commission on Health Care "as much as 20 to 30 percent of all things done by well-meaning physicians in good hospitals is either inappropriate, ineffective, unnecessary and sometimes harmful."

Bargaining affordable family health coverage for workers in low-wage industries has been an especially difficult task ever since the late seventies. But current cost trends are challenging the ability of union negotiators even to maintain affordable coverage established years ago for middle income workers and retirees.

For those of us in the labor movement, the healthcare crisis isn't just another fascinating policy debate. It hits us in the face everyday at the bargaining table.

During the first wave of double-digit cost increases in the early 1980's, labor and management worked together to control costs through innovative cost control programs like mandatory second opinion surgery, and hospital utilization review.

For a while, such cost containment initiatives seemed to have a tangible effect in holding down inflation in employer sponsored health plans while maintaining long established levels of benefits.

But healthcare cost inflation is back—the average cost of coverage rose by over 20 percent in 1989.

Effective cost containment programs are getting harder to find. Many employers have given up on attempting to control costs and are now simply interested in shifting the risk of health inflation to workers. Cost shifting disguised as cost containment is what's forcing workers in increasing numbers to put up picket lines.

Last year, SEIU published a report that examined these trends through a survey of plans covering roughly one-fifth of SEIU's 925,000 members. Nearly 90 percent of the workers involved were in plans covering white-collar jobs in state and local governments with relatively good wage standards and benefit packages, including family health insurance.

The study paints a bleak picture for the future of employment-based health insurance. Among the major findings:

First, health coverage obtained through private insurance for middle income workers is in grave danger due to a sudden, large jump in the employee share of the cost of such coverage. Worker premium contributions for family plans in our survey jumped 70 percent over the two years, double the average 35 percent rise in employer contributions.

Second, low wage service workers in the private sector are even worse off. Although technically insured, their coverage is unaffordable. The study finds that more than a third of the disposable income of these workers would be required for premium contributions and deductibles alone—expenses which must be paid before insurance coverage kicks in.

The survey results point out an important missing dimension in the health access debate: the erosion of private health insurance coverage isn't limited to the 37 million uninsured people in our country.

Millions more have employment-based coverage only on paper. Workers increasingly find their health benefits unaffordable as employers push an ever-larger share of the rapidly rising health costs onto their budgets.

These two trends—more jobs without insurance and more jobs with unaffordable insurance—are rapidly destroying the private insurance base of our country's health care system.

The labor movement will continue to bargain aggressively to hold the line on health benefits, while working with management to achieve genuine cost savings. But we recognize that it's not the long-run solution to our nation's health crisis.

That's because the roots of our inability to rein in healthcare costs lie in the multiple financing mechanisms that characterize the U.S. delivery system. With thousands of public and private health plans, cost containment amounts to little more than each plan trying to shift costs elsewhere in the system.

Meanwhile, the Federal Government is busy shifting its' Medicare costs to retirees and employers. By bearing down on hospital costs, Medicare has now shifted much of the care for the elderly to the outpatient side. Under Part B, seniors, or the former employers of those with retiree coverage, are responsible for 20 percent of the bills.

In turn, employers saddled with skyrocketing costs and new corporate accounting rules that threaten their bottom-lines are looking to get out of the retiree health business altogether. So they are shifting their rising costs to retirees through higher co-pays and fixed caps on their contributions, reducing coverage by requiring longer service to qualify, and ending benefits for future retirees.

And, of course, employers without health coverage for their work force are getting a "free ride"—shifting their costs to everybody else.

It's a vicious cycle.

This deepening crisis in health care is forcing consumers, purchasers and even some providers to speak out on the need for change—for a solution to the American healthcare dilemma. Unfortunately, there is no consensus yet on what these policies should be

During the 1980's Congress has addressed access to health care in a piecemeal fashion. The battle of the budget may dictate continuation of this approach.

SEIU continues to support incremental efforts such as the expansion of Medicaid coverage. But further action is necessary before the private insurance system collapses.

We believe further action is needed both to control costs before the private insurance system totally unravels—and to improve the quality and appropriateness of care.

We need a plan to move quickly to ensure universal access, with effective cost control mechanisms, and new standards of quality assurance.

We need, in short, systemic reform carried out at the national level. In recent months a host of comprehensive U.S. reform initiatives have surfaced: ranging from public-private partnership models, such as the National Leadership Commission on Health Care and the voucher-based system advocated by the Heritage Foundation; to Canadian-style national health insurance proposals from a physicians' group and the Committee for National Health Insurance.

I urge the Subcommittee to weigh all the reform proposals which are now being put forward and to bear in mind the lesson of labor's experience in recent years: that private insurance, arranged on a voluntary basis, is falling substantially short of the mark.

The direction taken has important budgetary considerations. Currently, a significant expansion in Medicaid eligibility alone would add significantly to the Federal budget deficit, as low-wage employers would dump their workers onto the public rolls. Similarly, without Medicaid expansion, employer mandates alone are problematic: unless copayments and deductibles are picked up by Medicaid, the high levels of stop loss in mandated minimum health benefits proposals will recreate the access problem for low-wage workers. Further, some Americans have no ties to the work force.

An alternate approach lies in a modified Canadian-style system, with government based financing and private delivery of care. In a recent Harris poll, two-thirds of Americans favored moving to a Canadian-type system. The appeal lies with Canada's combination of unqualified, universal access and the ability to control costs.

The efforts of the Senate Finance-Labor Working Group, led by Senator Riegle and Senator Kennedy, are moving in the right direction. The public-private partnership approach builds on what exists while clearly calling for universal access. At the same time, the Working Group is emphasizing the need to develop systemic cost containment mechanisms. Out-of-control costs are what's driving the access problem and undermining our job-based system of health coverage.

The present moment requires strong Federal leadership to steer us out of the dangerous cross currents and to fashion a national plan to solve the triple problems of declining access, high costs and uncertain quality.

The call for national health reform is being echoed in many quarters. Now is the time to turn the growing consensus for national reform into a plan of action.

Thank you.

PREPARED STATEMENT OF WALTER B. MAHER

[Feb. 15, 1990]

I appreciate the opportunity to share with you our views on the problems health care costs pose for America: problems of fundamental equity for uninsured citizens and problems of affordability and competitive viability for business.

The uproar Congress heard last term from the senior population regarding the Medicare Catastrophic Care Act was, in part, an expression of the same frustration felt by the business community and the labor movement regarding how the cost of health care is eroding standards of living and sapping industrial strength.

Fortunately, it appears there exists a virtual consensus in the country that our health system is substantially flawed and requires a massive overhaul. The problem is one of huge proportion, and any solution will require scrutiny of the financial incentives present in our system which are a byproduct of the way we have elected to pay for health care in America. Two key government panels are hard at work on the issue of system reform: The Pepper Commission and the Quadrennial Advisory Council on Social Security. In addition, various private sector groups are groping for solutions. No one, to my knowledge, is advocating maintenance of the status quo.

The private sector has been hard at work on the health cost problem for years. In mid-1981, Chrysler established America's first Board of Directors'-level committee devoted exclusively to analyzing Chrysler's health care cost problem and searching for solutions. Since that time, a substantial number of cost management initiatives have been adopted and even more actions are planned. Despite these actions, Chrysler has seen its per capita cost of providing health coverage to employees and retirees increase at an average annual rate of over 8 percent since 1981. While this was substantially better than the average business' experience, it nevertheless represented a rate of increase which exceeded both CPI and GNP growth. In short, we and many other businesses are in danger of being run over by the health care juggernaut.

Americans spend about 40 percent more per capita on health care than the second most expensive country in the world (Canada) and we are well over 100 percent more expensive than Japan. We spend almost 90 percent more than West Germany, a country having a population much older than ours and which prides itself on its reliance on high-tech medicine and on its advanced, research-oriented pharmaceutical industry. These statistics (See Exhibit I) would not necessarily be so frightening if we were getting our money's worth. America, however, ranks well down the list in both life expectancy and infant mortality; there is virtually no health professional who does not readily admit to the existence of wastefulness in the delivery and consumption of health services; and despite all these expenditures, there are 37 million U.S. citizens without health coverage.

This massive overconsumption of health services in the U.S. does not occur in a vacuum. Three, segments of our society have been particularly hard hit. On the patient side of the equation, tens of millions of citizens have either been denied access to the system or squeezed out of it, in large part because of the cost of care. On the payor side, small businesses, the majority of whom offer coverage to employees, have been hit with staggeringly high cost increases and often lack the internal resources to soften some of these blows by negotiating more favorable arrangements with PPO's and otherwise engaging in sophisticated analytical efforts designed to target in on specific health cost management strategies. Further, insurance company administrative charges relative to benefit dollars paid out are often considerably higher for small business than for larger concerns.

The other segment of our society that has been severely impacted by the high costs inherent in the U.S. health system are those businesses involved in international competition. Any company in America offering health coverage to employees must pay into a health system which has escalated in cost dramatically, consumes almost 12 percent of our nation's GNP and requires substantially more money to operate than health systems in other countries.

Business is quite limited as to what it can do in response to this problem, other than managing its benefit programs as effectively as possible. It cannot import a cheaper product from abroad. Those involved in competitive markets (like the fiercely competitive automobile business) cannot raise prices at will to recoup higher health costs. Instead, what results is a classic squeeze on profits. her profits reduce the funds which would otherwise be available for investment in research, new products and job creation. Lower profits also result in a reduction of tax revenues for investment by government in infrastructure improvement, including vital areas such as education.

The strategies that appear to be most in use by business are a combination of cost-shifting to employees, managed care efforts with varying levels of success, and other efforts to reduce labor costs by the automating or outsourcing of jobs. One person has suggested that U.S. firms engaged in international competition could adopt a strategy of reducing workers' pay to compensate for the difference between U.S. and foreign health costs. It should be quite clear, however, that any business adopting a long-term strategy of gradually impoverishing employees to make up for escalating U.S. health costs, just might find it hard to retain employees, not to mention hiring replacements. There are, after all, countless employers in America not engaged in foreign competition.

Consequently, business and labor groups from across America have made the health cost crisis one of their top public policy issues. My company is quite concerned about the competitive damage inherent in the dramatic difference between U.S. and foreign health costs. Seven hundred dollars of the cost of every U.S.-built Chrysler car goes to support the U.S. health system (Exhibit 2). We must compete with foreign automakers having a $300 to $500 per car advantage over us due to health costs alone (See Exhibit 3). Coming off 1988, which saw business health costs in general increase a reported 22 percent, Hewitt Associates, a leading employee benefits consulting firm, forecasted 1989 costs would increase another 21.5 percent. American business clearly cannot continue funding such a health care system and succeed against international competitors. Chrysler does not object to playing a role in financing our country's health system. All of our international competitors, in one way or another, finance their countries' systems. What we do object to is the fact that, put in its broadest, macroeconomic perspective, America's health care system creates a type of export tax, since many significant exports from the U.S. are produced by its largest companies which traditionally offer good employee health benefit plans. Given this perspective, the system actually contributes to the U.S. trade deficit and impairs competition on many levels.

What is equally disconcerting is the fact that, while our country is debating whether we really must engage in major system reform, much of the rest of the world is going to work to reduce their health costs. There is a serious move among the public and private sectors in Europe to develop strategies to make their health systems even more efficient. The Japanese are doing the same thing. Therefore, we run the risk in America of only exacerbating our problem if we do nothing and, at best, retaining the current huge competitive disadvantage if we simply tinker.

We submit that fundamental change is required. In that respect, it appears we have a lot of company. In a recent survey, 89 percent of Americans questioned expressed a need for substantial health system reform. And no wonder. Business pays only about 25 percent of America's health care bill. Federal, state and local government programs pay 40 percent of the tab (using citizen tax dollars, of course); and individuals pay 33 percent, the bulk of the balance, either through direct patient payments or private insurance premiums. This represents a painfully high, yet quite subtle, surtax on all Americans, in dollar amounts which grow every year forcing lifestyle tradeoffs and, more often than not, eroding living standards.

How big is this problem? At least $100 billion a year. As Exhibit 4 shows, while wealthier countries tend to spend relatively more on health care (as well as on consumer items like cars, Levis and VCRs) than poorer countries, the well-recognized relationship between per capita health spending and per capita wealth holds essentially firm for all countries except the United States. The United States lies well above the trend line, more than $400 per capita higher than it would be based on the average relationship found for the other countries depicted.

The causes of this problem are legion, but a factor undoubtedly contributing to most of them is that America's health system per se has never had to cope with any semblance of a resource limit. Further, health care has not appeared to be the type of good or service where purchasers, at least up to now, have been able to step in and regain overall control. One reason is that health care, itself, is big business in America. Reclaiming $100 billion will not be easy. The essence of any business is to grow, not shrink. That philosophy is imbedded within most all the major players comprising our country's health care system. This includes not only doctors and hospitals, but others, such as pharmaceutical and medical equipment manufacturers. Health care is mass marketed in America and, like any other successful marketing program, consumers respond. Therefore, when the subject of health system reform comes up, proponents of reform are told about Americans' strong appetite for health care; that Americans would not put up with this or that; that more is better. We hear that, however, from the sellers of health care, *not* consumers.

As a result, based on analyses of both Medicare and private sector health benefit utilization, we have a health system in America which encourages the provision of a high volume of unnecessary or questionable medical services, we observe significant variations in physician practice patterns with no difference in patient outcome, and new technology is substantially overused; (most of the above receives a powerful stimulus from the malpractice crisis that envelops medicine)

Is change necessary? Is there some magic solution about to appear as a result of all the work done during the past decade by the public and private sectors in searching for a solution? I fear not. Over the past three decades, with the sole exception of the two oil shock years, health care has outstripped CPI growth. If anything, the gap has widened during the alleged era of cost containment. joking ahead we face these real facts:

- The elderly consume more health services than the non-elderly.
- The elderly, as a percentage of the total population, are growing.
- If health care inflation is permitted to continue at two or more times the rate of CPI growth, health care will slowly consume the GNP.
- In fact, if health care is permitted even to increase at the rate of CPI growth, it will consume more and more of the GNP as the elderly grow in number, forcing more societal tradeoffs.

It appears to us that, given these inescapable facts and the fact that we are so uncompetitive now, tinkering around the edges of our system will not suffice.

If we examine the health systems other countries have adopted, while they vary widely, we find two common denominators: They provide protection for all their citizens, and they have effectively established a process which provides some measure of control over how much of a country's resources its health system can consume. While the U.S. health care system has many wonderful attributes, these two features are missing. I submit we can embrace them without detracting from the good our system has to offer.

There are many potential solutions to this problem being examined by interested parties around the country. One solution under review by a group of businesses, if adopted universally, would essentially require employees and those covered by public programs to seek care only from designated providers to obtain maximum plan benefits. The ultimate such private program, for example, would see an employer actually hiring doctors and requiring employees to obtain care from them.

Other alternatives being examined resemble the centralized programs found in Canada and France.

Still others would offer somewhat more pluralistic models, such as are found in Germany and Japan.

Chrysler is interested in the *result,* a more rationally priced U.S. health care system, not necessarily the process selected to realize the result, so long as the process is acceptable to U.S. citizens and does not disadvantage businesses engaged in international competition.

With reference to who pays for the system, Chrysler believes all segments of the economy, including all employers and potential consumers of health services, should contribute to the financing of the U.S. health care system. Chrysler's foreign competitors, particularly those in Japan, Germany and France, contribute significantly to their countries' health care systems. Thus, to enjoy a level playing field, it is not necessary for business to dump its cost on someone else. However, as noted earlier, the costs of foreign systems are significantly less than U.S. costs, thereby creating a marked competitive disadvantage for U.S. employers engaged in international competition.

A genuine problem exists relative to those small businesses who currently do not offer health insurance to employees. If government wishes to involve them in the financing of our nation's health system (and I fail to see how we can rationalize any reformed system where any segment of the economy is exempted from participating in its financing) then government must respond to the concerns of small business. Initially, full tax deductibility of health premiums should be available to the self-employed and any private employer. More fundamentally, however, it would be improper for government to mandate that an employer directly or indirectly offer insurance without at the same time assuring that employer it was buying into a rationally-priced system and one whose annual cost increases were predictable. Thus, I would give such employers, indeed all employers, the option of buying into a Federal or federal/state community-rated program incorporating reasonable but tough managed care features and expenditure controls.

Regarding the management of health costs, there are lessons to be learned from recent recommendations to Congress by the Physician Payment Review Commission (PPRC), many of which were incorporated in the Omnibus Budget Reconciliation Act of 1989. I believe these recommendations point towards a direction requiring serious consideration for inclusion within a reformed U.S. health system:

- To rationalize the current pattern of payments among physicians, which has overpriced and promoted an inappropriate volume of many surgical and technical procedures and undercompensated evaluation services, the Commission proposed, and Congress adopted, a methodology to revise the Medicare fee schedule to base payments primarily on the resource costs incurred in efficient medical practice.
- To help assure the delivery of quality, effective health care, the Commission proposed, and Congress agreed, that funding should be provided to support effectiveness research and practice guideline development. The development of practice guidelines may not only serve to reduce unnecessary services and improve quality, but may also provide protection from malpractice liability for physicians who follow them. It would, in addition, facilitate the operation of managed care systems.
- To control year-over-year growth in spending for physicians' services, annual expenditure targets were proposed and subsequent years' rate of fee increase would take into account overall compliance with the target. In the absence of effective practice guidelines, we believe this was a particularly appropriate recommendation. The AMA responded as would be expected, objecting strenuously. While Congress made some changes, including changing the name "Expenditure Target" which the AMA recoiled at, to "Volume Performance Standards," the fundamental objective of the recommendation remained unchanged.

The AMA argued that setting expenditure targets would cause a rationing of health services in America. First, we should never fear rationing excess; instead we should seek to eliminate it. Second, we should not entertain such arguments until the medical experts who are regularly reporting on the high volume of unnecessary and ineffective medical care rendered in this country report that that problem has disappeared. In short, the rationing scare-tactic employed by some in the medical community, insofar as it is intended to relate to necessary health services, or that it is an inescapable result of any tough cost management effort, is just bunk.

Finally, we believe it is not reasonable to assume you can accomplish overall system reform without involving government in the solution. Today, Federal, state and local government programs account for 40 percent of the health services purchased in the U.S. Accordingly, the manner in which such programs are operated, including the prices paid, utilization controls or the absence thereof, and other reimbursement policies, and the populations and services covered or not covered, has the capacity to substantially impact the behavior patterns of health services providers, the prices charged to private sector purchasers, the funds available for capital expansion and medical education programs, and, in general, the entire U.S. market for health services. The same market from which the private sector must purchase health services.

Further, Federal tax policy has contributed significantly to the development and growth of private sector health plans.

Accordingly, Chrysler believes it is essential that the Federal Government participate actively with the private sector if we are to have a rational health policy for America. Acting effectively in its various capacities as the sponsor of public health programs, as a standard setter and as the developer of tax policy, the Federal Government can help chart the course for such a policy which is so desperately wanting if we are to meet the needs of U.S. businesses whose competitive strength is being sapped, and the needs of all U.S. citizens whose standard of living is being eroded by excessive health care costs. It can fulfill this role in one of two general ways—either by establishing the overall ground rules within which public and private sector programs must operate to accomplish our nation's health care objectives. The other way is for government to assume a more dominant role in the administration of the system. I, personally, do not see any other solutions at this time which hold promise for success.

The public and private sectors should embrace a national objective to reduce the cost and improve the value of the U.S. health system. Inherent in this must be a commitment by the public sector to provide coverage for all of society's poor and to assure that provider reimbursement for public program beneficiaries is fair and does not lead to cost shifting to private sector plans.

Indeed, the private sector has a vested interest in seeing to it that programs like Medicare and Medicaid are operated in a manner that does not adversely prejudice private sector plans. Ideally, public programs should be operated in a manner consistent with improving the quality and cost effectiveness of private sector plans. In this regard, the Federal Government should accelerate the introduction of managed care techniques and the adoption of the PPRC and other like recommendations as elements of both the Medicare and Medicaid programs. Further, as a top priority, it should initiate reform measures to address the cost, quality and access problems caused by medical malpractice litigation. This should, of course, include measures designed to prevent malpractice.

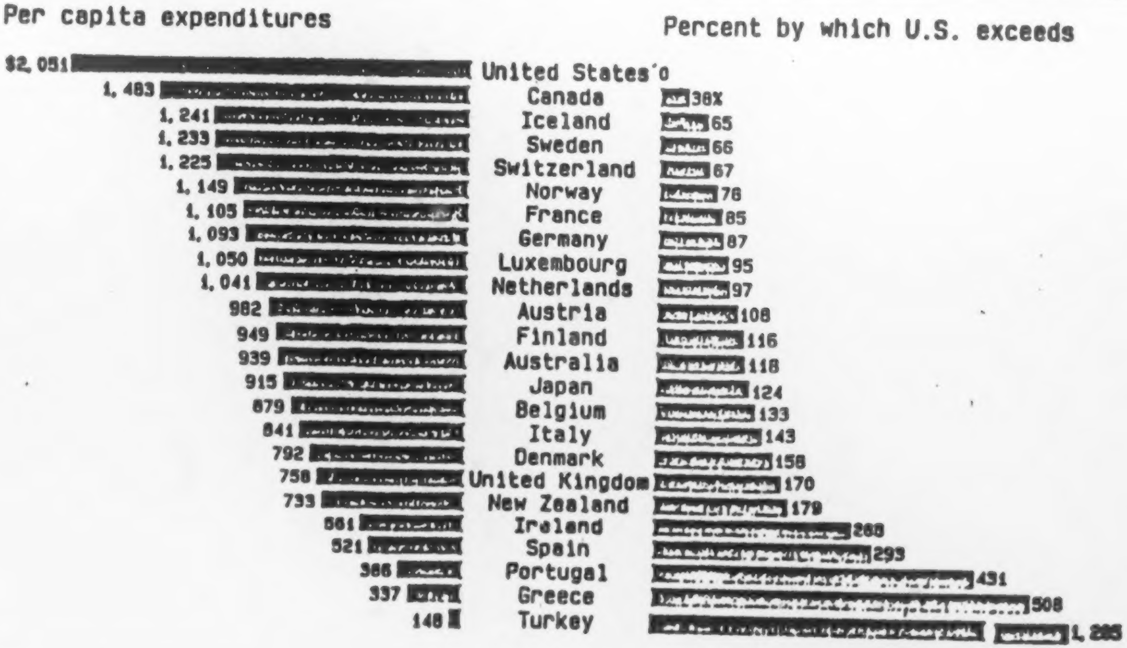
Regarding Federal tax policy, some argue that this policy has contributed to unreasonably costly health plans based on unreasonably generous benefit levels. Some have suggested addressing this by imposing a fixed dollar limit on the cost of health plans which could be excluded from income tax liability. If the purpose of such a change is to provide an incentive for employers and employees to adopt cost-effective health plans, then setting a fixed dollar limit is the wrong tool. An employer with a young work force may easily be able to live within such a cap with a rich, unmanaged plan. Likewise, an employer with an older work force having a reasonable, well-managed plan may overshoot the mark. The emphasis, I submit, should be on the benefit plan design and whether such a plan design is consistent with the dual national objective of cost reduction and value enhancement, and not simply the absolute level of the cost of providing services to plan beneficiaries, regardless of their age or health status.

In conclusion, I believe it is important for the facts regarding our nation's health system to be exposed for the public to view. It is clear to me the public does not fully understand how bad the problem is and how it impacts them, even if they have insurance. American citizens ultimately pay the total price for our health care system. We pay in the form of increased doctor bills, heftier insurance premiums, and increased taxes. The ability of our employers to increase wages is influenced. The prices of goods and services we buy are also affected. Citizens also are victims of a deteriorating national infrastructure, an inferior education system, and many other indicators of a government strapped for funds, in part because of our nation's high health costs. Worst of all, citizens are at risk of paying the supreme price of losing a job, because their employer's business failed due in whole or in part to the unconscionably high cost of health care in America or because their employer automated or outsourced their job in hopes of reducing labor costs.

A *business* can do that; it can reduce health costs by reducing the number of employees, in short by reducing the number of patients. A *nation* should not have to do the same thing. It should not have to export citizens to reduce health costs. Nations do, however, export jobs a,and that is what is going on in America today and what will continue to occur until we decide to take the bold steps necessary to make our nation's health system cost competitive.

Thank you.

Exhibit 1
Per capita health spending, 1987

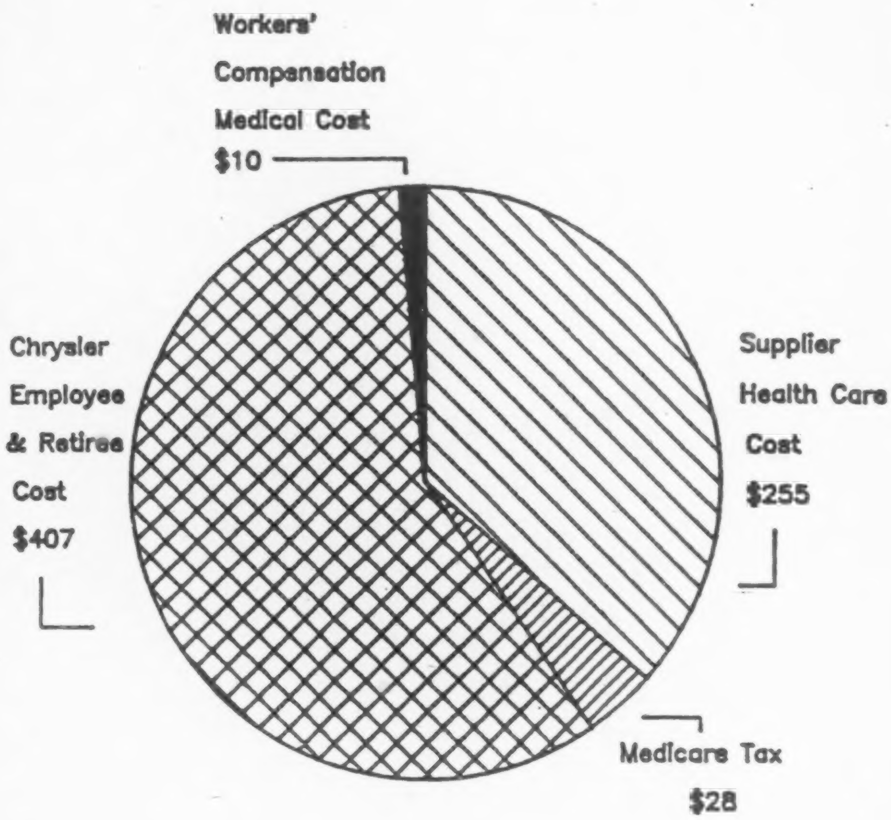


SOURCE: Organization for Economic Cooperation and Development, Health Data Bank.

Exhibit 2

CHRYSLER HEALTH CARE COST PER VEHICLE

1988 – U. S.

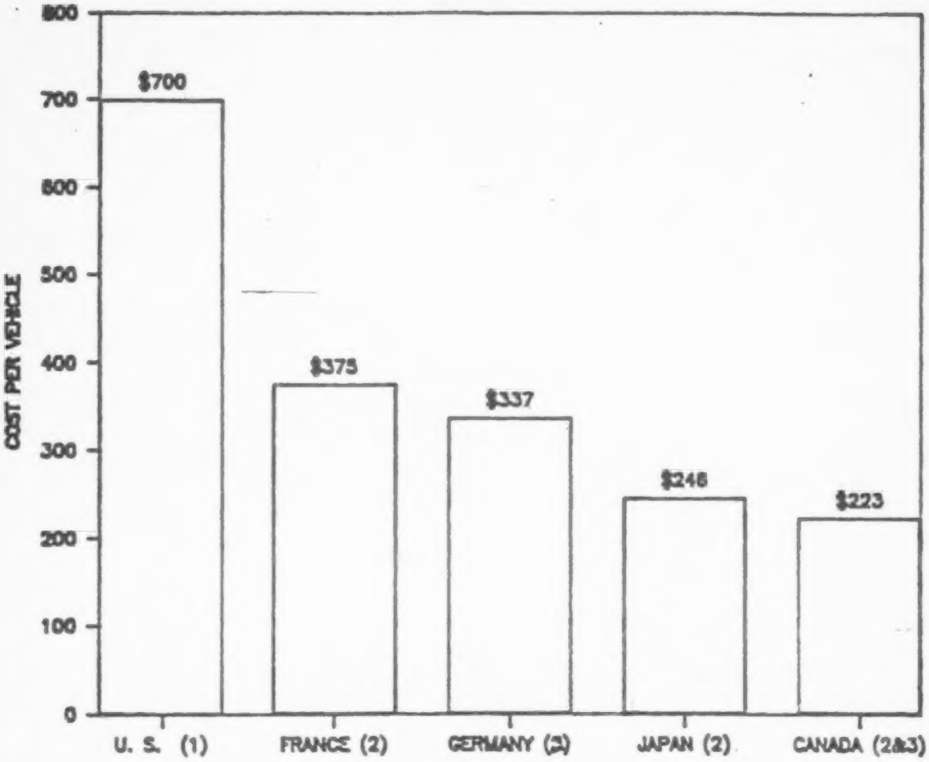


TOTAL: $700

Exhibit 3

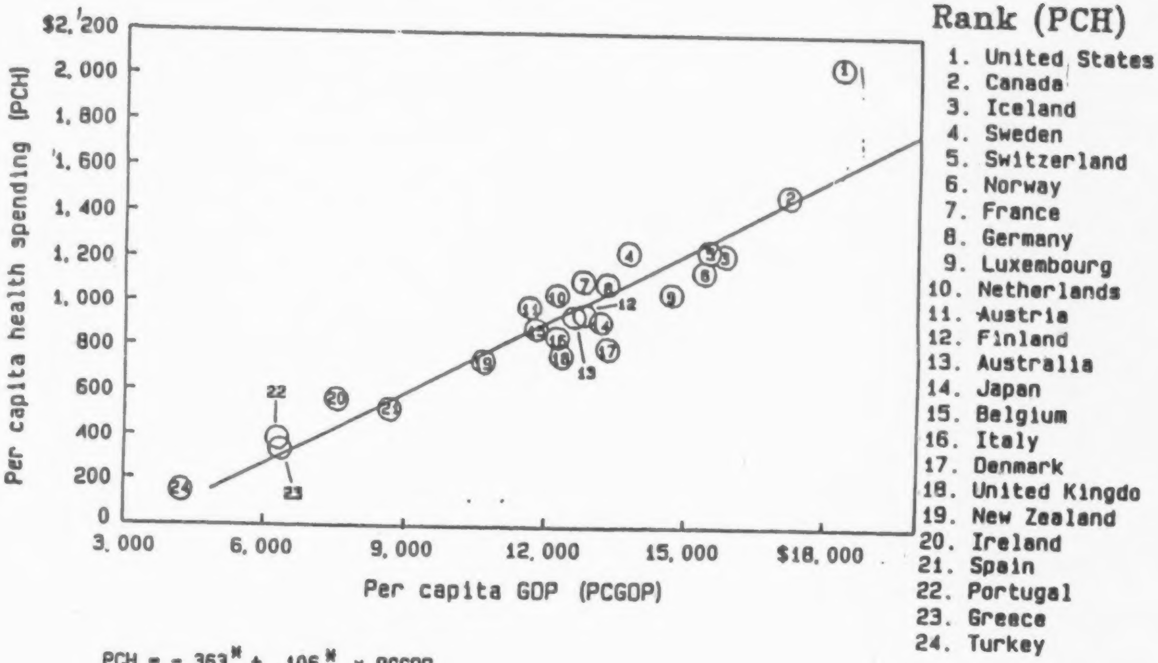
HEALTH CARE COSTS PER VEHICLE

–1988–



(1) Includes employee and retiree premiums, Medicare payroll taxes, Workers' Compensation Medical costs and imputed supplier health care costs.
(2) Includes payroll taxes and imputed supplier health care costs.
(3) Excludes general tax payments

Exhibit 4
Per capita health spending and per capita GDP, 1987



$PCH = -363^{*} + .106^{*} \times PCGDP$

$\bar{r}^2 = .86$

* = Statistically significant at .01 level

PREPARED STATEMENT OF WALTER B. MAHER

[April 18, 1990]

Chrysler appreciates this opportunity to comment on some of the options being considered to assure access to affordable health care for all Americans.

We are gratified that both the Pepper Commission and the Bi-Committee Bi-Partisan Senate Working Group on Universal Access addressed both the high cost of health care in America and the large number of uninsured in their recently issued recommendations and proposed options. These two issues are inextricably linked.

No nation on earth has embarked on a program providing all citizens access to health care without concurrently adopting a strong, coordinated plan to help assure control of costs. This is an extraordinarily important fact, and we urge you to keep it constantly in mind as there are many forces at work who will try and convince you that tough cost controls are not possible in America. They are, and they must be.

The private sector has been hard at work on the health cost problem for years. In mid-1981, Chrysler established America's first Board of Directors'-level committee devoted exclusively to analyzing Chrysler's health care cost problem and searching for solutions. Since that time, a substantial number of cost management initiatives have been adopted and even more actions are planned. Despite these actions, Chrysler has seen its per capita cost of providing health coverage to employees and retirees increase at an average annual rate of over 8 percent since 1981. While this was substantially better than the average business' experience, it nevertheless represented a rate of increase which exceeded both CPI and GNP growth. In short, we and many other businesses are in danger of being run over by the health care juggernaut.

The massive overconsumption of health services in the U.S. does not occur in a vacuum. Three segments of our society have been particularly hard hit. On the patient side of the equation, tens of millions of citizens have either been denied access to the system or squeezed out of it, in large part because of the cost of care. On the payor side, small businesses, the majority of whom offer coverage to employees, have been hit with staggeringly high cost increases and often lack the internal resources to soften some of these blows by negotiating more favorable arrangements with PPO's and otherwise engaging in Sophisticated analytical efforts designed to target in on specific health cost management strategies. Further, insurance company administrative charges relative to benefit dollars paid out are often considerably higher for small business than for larger concerns.

The other segment of our society that has been severely impacted by the high costs inherent in the U.S. health system are those businesses involved in international competition. Any company in America offering health coverage to employees must pay into a health system which has escalated in Cost dramatically, consumes almost 12 percent of our nation's GNP and requires substantially more money to operate than health systems in other countries.

Business is quite limited as to what it can do in response to this problem, other than managing its benefit programs as effectively as possible. It cannot import a cheaper product from abroad. Those involved in competitive markets (like the fiercely competitive automobile business) cannot raise prices at will to recoup higher health costs. Instead, what results is a classic squeeze on profits. Lower profits reduce the funds which would otherwise be available for investment in research, new products and job creation. Lower profits also result in a reduction of tax revenues for investment by government in infrastructure improvement, including vital areas such as education.

The strategies that appear to be most in use by business are a combination of cost-shifting to employees, managed care efforts with varying levels of success, and other efforts to reduce labor costs by the automating or outsourcing of jobs. One person has suggested that U.S. firms engaged in international competition could adopt a strategy of reducing workers' pay to compensate for the difference between U.S. and foreign health costs. It should be quite clear, however, that any business adopting a long-term strategy of gradually impoverishing employees to make up for escalating U.S. health costs, just might find it hard to retain employees, not to mention hiring replacements. There are, after all, countless employers in America not engaged in foreign competition.

Consequently, business and labor groups from across America have made the health cost crisis one of their top public policy issues. My company is quite concerned about the competitive damage inherent in the dramatic difference between U.S. and foreign health costs. Seven hundred dollars of the cost of every U.S.-built Chrysler car goes to support the U.S. health system. We must compete with foreign automakers having a $300 to $500 per car advantage over us due to health costs alone. We are likewise at a disadvantage compared with new foreign-owned firms locating in the U.S. which, while offering similar benefit plans, employ a much younger workforce.

The Pepper Commission and Working Group recommendations address many concerns of the business community. The expansion of public program coverage for the poor is long overdue, as is increasing Medicaid reimbursement for doctors and hospitals. All publicly-financed health programs should be operated so as not to cause providers to shift costs to private sector payors. This, I submit, is a must if we are to go forward with a public-private partnership in addressing the health care access/cost issue.

Malpractice litigation reform is likewise an urgent problem requiring immediate attention at the Federal level, and we were pleased to see it prominently mentioned in the recommendations.

The Pepper Commission recommendations were much less aggressive than we had hoped for regarding overall health system cost control. As a nation we are currently overspending on health care at the rate of $100 billion per year, almost 40 percent more per capita than the second most expensive country on earth. In addition to those initiatives recommended by the Commission, expenditures for capacity expansion and renewal and for technology development and diffusion merit special attention. Further, the subject of medical education expenditures, particularly if they contribute to a proliferation of specialists and sub-specialists at a time when we need more primary care and family practitioners, requires scrutiny. Finally, establishing a process to help assure aggregate U.S. health expenditures are more consistent with effective medical practice and costs in other leading countries is a concept we believe deserves to be included in any health system reform package.

Chrysler is convinced that to accomplish overall health system reform, satisfying business concerns regarding cost and public concerns regarding access, government must be involved in the solution. The reason, we believe, is obvious: Federal, state and local government programs account for 40 percent of the health services purchased in America and the percentage is likely to grow. Accordingly, the manner in which such programs are operated, including the prices paid, utilization controls or the absence thereof, and other reimbursement policies, and the populations and services covered or not covered, has the capacity to substantially impact the behavior patterns of health services providers, the prices charged to private sector purchasers, the funds available for capital expansion and medical education programs, and, in general, the entire U.S. market for health services the same market from which the private sector must purchase health services.

Further, Federal tax policy has contributed significantly to the development and growth of private sector health plans.

Chrysler also believes that the cost of health care should be spread more equitably among individuals, business and government. Exporters to the U.S. should help finance our country's social programs as U.S. firms do when they export and pay VATs. Health plan beneficiaries must have a financial stake in the efficient operation of their health plan. We also believe participation by all employers in the financing of health care is an essential ingredient to a solution.

That being said, we concur with Senator Rockefeller that the government cannot reasonably mandate participation in a health system that is broken. Government should not mandate any employer into a system without at the same time assuring that employer it was buying into a rationally-priced system and one whose annual cost increases were relatively predictable.

One way to provide such assurance and to accelerate the whole system reform process would be for government to take the steps necessary to assure that the new public program or programs contemplated by the Pepper Commission's recommendations (whether Federal or state-administered) be models of efficiency, with built-in spending controls and relative certitude regarding annual inflation. All employers should have the unfettered option of buying into such a plan on a community rate basis which should serve to spur the private sector to come up with even better products.

Some may reasonably ask: What assurance is there that government can run an efficient system? I submit it all comes back to a requirement that government be required to operate programs like Medicare and Medicaid in a manner whereby it pays fully for services rendered, including its fair share for hospital capital and medical education. Given that starting point, government must then contend with the following facts:

- For the foreseeable future, government will be under fiscal constraints to contain the cost of public health programs and not exacerbate the Federal deficit.

- Government, however, under this scenario will be prohibited from realizing its cost objective by shifting costs to the private sector.
- Government, likewise, will be constrained by the political clout of the beneficiary population (notably seniors) from realizing its cost objective by diluting the quality of the public health program.
- For the foreseeable future, government will be under fiscal constraints to contain the cost of public health programs and not exacerbate the Federal deficit.

- Government, however, under this scenario will be prohibited from realizing its cost objective by shifting costs to the private sector.
- Government, likewise, will be constrained by the political clout of the beneficiary population (notably seniors) from realizing its cost objective by diluting the quality of the public health program.

- Government will also be constrained by the political undesirability of raising taxes as a means of financing an uncontrolled public health plan.
- Accordingly, government will be compelled to run an efficient health plan, one embodying the best managed care techniques available.

Given the above, we submit that providing any employer the option of buying into such a plan should alleviate many concerns about the availability of affordable health coverage. Further, if offering a certain level of health coverage is to be expected of all employers, then *at least as to the cost for such coverage* an employer should be neither advantaged or disadvantaged based on employee demographics or the location of a business. Having the opportunity to buy this coverage at no more than a community rate would also help ensure that employers would have no incentive to discriminate against employees on the basis of the number of their dependents or their prior medical history.

A major problem the health system reform debate must contend with is how to address the legitimate concerns of the very small business person. Seventy-five percent of U.S. businesses employ fewer than ten persons. The majority of them do not currently offer health coverage. In the aggregate, 46 percent of U.S. employers do not offer coverage. While they employ only IS percent of the nation's workers, they represent an obstacle to universal access *if* employer-based coverage is to be the chosen financing vehicle.

If the concerns of these employers cannot be satisfied, we believe it would be appropriate to consider some alternative way for *all* businesses to help contribute to the support of the U.S. health system, e.g., through the tax system.

Chrysler is pleased to see emerging a growing consensus that fundamental change is required. In a recent survey, 89 percent of Americans questioned expressed a need for substantial health system reform. And no wonder. Business pays only about 25 percent of America's health care bill. Federal, state and local government programs pay 40 percent of the tab (using citizen tax dollars, of course) and individuals pay 33 percent, the bulk of the balance, either through direct patient payments or private insurance premiums. This represents a painfully high, yet quite subtle, surtax on all Americans, in dollar amounts which grow every year forcing lifestyle tradeoffs and, more often than not, eroding living standards.

The causes of this problem are legion, but a factor undoubtedly contributing to most of them is that America's health system per se has never had to cope with any semblance of a resource limit. Further, health care has not appeared to be the type of good or service where purchasers, at least up to now, have been able to step in and regain overall control. One reason is that health care, itself, is big business in America. Reclaiming $100 billion will not be easy. The essence of any business is to grow, not shrink. That philosophy is embedded within most all the major players comprising our country's health care system. This includes not only doctors and hospitals, but others, such as pharmaceutical and medical equipment manufacturers. Health care is mass marketed in America and, like any other successful marketing program, consumers respond. Therefore, when the subject of health system reform comes up, proponents of reform are told about Americans' strong appetite for health care; that Americans would not put up with this or that; that more is better. We hear that, however, from the *sellers* of health care, *not* consumers.

Another red herring often heard is that any effort to get tough on the cost side of the equation would cause a rationing of health services in America. First, we should never fear rationing excess; instead we should seek to eliminate it. Second, we should not entertain such arguments until the medical experts who are regularly reporting on the high volume of unnecessary and ineffective medical care rendered in this country report that that problem has disappeared. In short, the rationing scare-tactic employed by some in the medical community, insofar as it is intended to relate to necessary health services, or that it is an inescapable result of any tough cost management effort, is not supportable.

Evidence of delays in providing certain elective services in Canada, for example, are often cited by some. First, Canada is in its thirtieth year of hospital controls and its twentieth year of physician controls and has relied almost exclusively on resource constraint to accomplish its cost objectives. Accordingly, it is not surprising that there exists today a certain tightness in parts of their system. More fundamentally, however, and notwithstanding the exceptionally high approval rating Canadian citizens give their health plan, it appears that if Canada were to employ some of the managed care techniques in use in America, they would generate additional savings which could be used to add resources to their supply side and yet operate their system at a lower overall cost than they do today. You need appropriate controls on both the supply and the delivery side.

Finally, a word regarding the role of insurance companies in a reformed health system. We are suffering today from an excessive dose of administrative costs which are a byproduct of our fragmented, uncoordinated system. We submit insurance companies will only have a role if they bring value added to the transaction. For example, packaging efficient networks of doctors and hospitals and selling such a package to employers can be quite consistent with a national strategy of enhancing the quality and reducing the cost of health care in America.

In conclusion, the process of accomplishing health system reform will be very tough. But, it will be tougher if we delay. While we can appreciate how this process of reforming a broken system must take seriously the concerns of hospitals, physicians and insurance companies, the overriding need of American citizens and American business to have an affordable and cost-competitive health system demands that we not overconcern ourselves with having to build on a shaky foundation. Any final legislation resulting from the Pepper Commission recommendations or from the options presented by your Working Group which presumes a continued role by business in financing health care must consider how that role will affect the cost of production in America and the resulting impact on international competitiveness.

We look forward to cooperating with you as the reform effort works its way through the legislative process.

PREPARED STATEMENT OF LUANN EICHLER NUNNALLY

My name is Luann Eichler Nunnally. I am the sister of Cheryl Eichler. Cheryl was a witness at the Senate Finance Subcommittee hearing on the uninsured held on June 28, 1989 in Southfield, Michigan. I have been asked to testify on her behalf.

Cheryl had Crohn's Disease for 13 years. She was first diagnosed as having Crohn's in 1976 when we lived in Florida. When we moved back to Michigan in 1977, Cheryl was admitted to Wayne County General; that's when she had her first surgery and the doctors removed part of her colon. She was in the hospital for 3 months at that time. Luckily, our mother was receiving assistance through the Aid for Dependent Children Program and because of this Medicaid, Cheryl was able to survive her first battle with Crohn's.

In 1982, Cheryl found employment at Manpower Services. Although she was able to support herself, her employer did not offer employees health care benefits. She then had another flair up of Crohn's. She waited 6 months before she went to the hospital because she had no insurance and didn't know how she would pay for her medical bills. She was eventually admitted into the hospital and in August of 1983, she had an ileostomy. She was able to apply and receive Medicaid to help cover the costs of the treatment.

She then found a job at 7-11 and, eventually, Cheryl was offered a salaried position and earned about $12,000 a year. By October of 1985, Cheryl was again suffering the effects of Crohn's. She waited some time before going to the hospital because 7-11 offered no health insurance benefits. Cheryl was always trying to get some kind of insurance so she wouldn't have to go through the ordeal of finding help each and every time she needed medical care. She called insurance companies like Blue Cross to find out how much it would cost to buy coverage. Because of her poor health history, the monthly payments were just too much for her to afford. She kept trying to apply for medical assistance through the state but she was always turned down either because she made too much money, had a job, a car, or did not meet the Medicaid Program's definition of disabled.

By September of 1986, Cheryl developed peri-rectal abscesses. But again, she didn't seek treatment until the end of 1987 or beginning of 1988 because she was very scared, had no insurance, and she didn't know how she was going to be able to pay for the treatment. Finally, in March of 1988, she had outpatient surgery for the abscesses. Cheryl set up a payment plan for this bill because she had no insurance and couldn't get any. She then started seeing her doctor about every two weeks and began paying for her prescription expenses. On May 15, 1989, Cheryl was forced to resign her position at 7-11 in order to be admitted into the Westland Medical Center. She was losing weight, was very run down, and was in a great deal of pain. Cheryl applied for Hill-Burton Funds from Westland Medical but was turned down because her $12,000 a year income was too great to qualify. She also applied for Medicaid but was told that she didn't meet the definition as disabled and was turned down. On June 28th, Cheryl was released from the hospital for the day to be a witness at the Senate Finance Subcommittee hearing for the Uninsured to tell her story. On June 29th, she was granted Medicaid. Within 2 weeks, she was released from Westland Medical. She was on a home IV system and a nurse came out to her house twice a week to check her.

Unfortunately, Cheryl became very ill in October with a severe infection and was admitted back into the hospital. On October 10, 1989, at the age of 29, Cheryl passed away.

I came here today on behalf of my sister Cheryl to urge everyone involved to please work to find a solution to the problem of the uninsured. The goal of the Senator's plan to provide health care coverage for all uninsured people is a most important one. I know all of the stress Cheryl went through in her 13 years of having Crohn's Disease without medical insurance. Because her employers did not offer health benefits, Cheryl was constantly trying to find another source of help. I know many others are feeling the same kind of stress and hopelessness at not knowing how they are going to pay for their medical bills or even if a hospital will admit them for treatment. I believe all business, big or small, should at least offer their employees some kind of insurance, even with a co-payment or deductible. Cheryl was willing to help pay for coverage. She just couldn't do it alone. Also, the government should change the qualifications for Medicaid in order to provide assistance to the uninsured who are unable to get coverage through their employer. I can't help but believe that Cheryl's life would have been different if she had received immediate medical attention throughout her illness.

I want to thank you Senator Riegle and the committee for giving me the opportunity to speak here today on Cheryl's behalf and on behalf of all the uninsured. We all must try to work together to help the uninsured. We're not just thinking of ourselves now, but we must also think of our children's future.

PREPARED STATEMENT OF CAROL RENAUD

My name is Carol Renaud and I am the wife and mother of four children. I testified for the Senate Finance Subcommittee on Health hearing that was held last June. I spoke about the problems my family had getting health insurance for my two six year old twin boys who have Downs Syndrome. Today, I would like to tell you about ourselves, bring you up-to-date on our current situation and share our feelings about your health care plan.

As I mentioned during the hearing, my husband Gary and I relentlessly searched everywhere for quality, affordable health insurance for Matt and Joe. We began by trying to get coverage through my husband's employer's insurance plan. We were successful in getting ourselves and our two normal children insurance benefits, but were told that because Matt and Joe had Downs Syndrome, they were not entitled. At the time, I didn't realize that insurance companies could just deny people coverage and that I would be battling for many years to get Matt and Joe some type of health insurance benefits.

We contacted everyone we could think of to help us with our struggle. We had the Association for Retarded Citizens (ARC) send letters to the insurance companies explaining Downs Syndrome and clarifying some of the misconceptions. In addition, my doctor wrote a letter stating that Joe and Matt were healthy boys and didn't have any major medical expenses. These attempts were futile, however, and led to my boys being red-flagged. When someone is red-flagged that means they will never be insured again.

To this day, Matt and Joe remain uninsured. I was offered a supplemental insurance policy through ARC, however, I declined because it only covers up to $100 a day for major medical treatment and my husband and I can't afford the yearly premiums. Also we don't think the plan is worthwhile because one could spend over a thousand dollars a day in the hospital for medical treatment. Since we both work, we do not qualify for any health care assistance through Medicaid. I am presently enrolled in school in hopes that when I graduate, I will be able to find a job that provides for insurance for my two boys; insurance coverage that I am not able to afford at this time.

Currently, the boys are doing fine and staying healthy. They have been to the doctors with a few colds and each' time they go, I am charged for an office visit. Ironically, I have not been to the doctor as many times as my other children who are entitled to health insurance benefits. I know that they probably would have gone more if they qualified for health insurance benefits, but it's too expensive. Once I took three of my children to the doctor and it cost me over $100 for the office visit. It makes me angry when I can't bring Matt and Joe to the doctor's office because I can't afford to pay the high cost of a check up. It forces me to put their health in my hands and play doctor at home. What if they had an ear infection and I didn't detect it? The sad fact is that I don't know how to detect an ear infection, but sometimes I just have to take the chance.

If the plan you are working on goes through, I know it will help a lot of working class people who aren't eligible for health care benefits through their employer. And if not the employer, then through the public insurance pool you are considering. Your plan guarantees that everyone is covered through either the private or public sectors. Many of my friends and family are working hard and proud that they're independent and not on public assistance. Like us, they are trying to teach their kids a strong work ethic and maintain their own self worth. The system falls short when we can't get access to an affordable, duality insurance program. We can't get it in the private sector because it costs too much or in the public sector because our income is to high. We feel that access to insurance is our only roadblock in caring for our children.

I am willing to take responsibility for providing health insurance for my children. If I can find a program available at a reasonable cost, I would be willing to pay for it. I would feel so much better contributing, rather than getting it for free because I would feel better about myself. I don't like getting things for free because it hurts my pride. If I can contribute, even if it is just a little amount, I would feel like I was really taking care of my sons.

I said in my last testimony that when Matt and Joe were born, I had the chance to give them up. If I had done so, the state would be taking care of them right now and probably providing them with health insurance. I believe, however, that I made the right decision. My kids are happy being at home. They are getting a chance to be educated, to play with children in our neighborhood and most importantly, to be a part of our loving family. It would make me so happy if I could also provide them with health care insurance.

Thank you for allowing me to testify.

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

Good Morning. Thank you for coming to this official hearing of the Finance Subcommittee on Health for Families and the Uninsured. Today, we will hear the views of Michigan Citizens and Experts on proposals we are considering in the U.S. Senate to solve the problems of 37 million Americans who have no health insurance. Tragically, 12 million of these are children, the most vulnerable members of our society. In Michigan, we have over 1 million people with no health insurance; close to 300,000 of whom are children.

Last year, the Subcommittee held a hearing in Southfield, Michigan to learn of the problems of people who have no health insurance coverage. Over 400 people attended to hear testimony from uninsured people, business and government leaders and providers. We have made a lot of progress from that time.

With the information gathered at that hearing together with other hearings in Washington, we are well on our way toward developing a comprehensive legislative solution to this tragic problem.

I have organized a bipartisan Senate working group with 12 members of the Finance and Labor Committees to develop legislation to solve the problems of Americans without health insurance. This type of effort between the two major committees on health in the U.S. Senate is unprecedented. The bipartisan working group in the Senate includes key Senate health policy experts—Senators Kennedy, Mitchell, Durenberger, Hatch. We have been working for the past 8 months on a private and public sector solution that will provide access to health care for all Americans. The working group will release a document for public comment in March after the recommendations of the Pepper Commission are released. My Subcommittee plans to move legislation on the uninsured this year.

The purpose of this hearing today is to give Michigan Citizens the opportunity to react to a variety of proposals I am considering. I plan to make this information available for my colleagues of the Senate Working Group.

We have some important witnesses that will testify. The individuals who testified at our Southfield hearing will bring us up to date with their problems. We will also hear from government and business experts as well as providers. I welcome others to submit their testimony in writing or orally to my staff. All testimony will be included in the official transcript of the hearing.

As most of you know, the U.S. has the highest per capita health care spending, over $1900 per capita. And U.S. spending on health, over $660 billion, is approaching 12% of the GNP, far exceeding any other nation in the world. High costs have forced families to absorb higher out-of-pocket costs because of cutbacks in employer-provided health care benefits and has led many to question whether we are getting appropriate value for our investment.

At the same time, there are ever growing and pressing needs. Over 37 million people do not have health insurance; and 14 million do not even seek care they feel they need because they know that they cannot afford it. In addition, uncompensated care costs, over $8 billion, drives up costs for everyone and is disruptive to our health care system. We know now that the uninsured span all ages, employment statuses, and income levels as the charts up front show.

Many people are falling through cracks in our employment-based system of health care. Two-thirds of all uninsured people are employed individuals and their family members. Medicaid—the program for low-income people is also inadequate, over one-third uninsured are poor. Medicaid only covers 40% of people below the poverty line. Our system of private and public programs leaves huge gaps in coverage that indicates a radical mal-distribution of resources.

This affects our ability to compete internationally. For example, Chrysler's health care cost per vehicle ($700) exceeds our international competitors' costs by from over $300 to almost $500 per vehicle. For America to compete in the world market place, all Americans have to be full partners; part of the team. And in order for people to be able to produce, they have to be educated and healthy.

The Finance Subcommittee on Health for Families and the Uninsured was created to focus attention on the uninsured and develop a solution and I intend to see that we accomplish this goal. I believe that the political dynamics around this issue have changed. No longer are we questioning the merits of solving problem. Question before us today is how to accomplish the goal of universal coverage in this country. One of my top priorities in this Congress is to see that all Americans have access to high quality, affordable health care—and together we can see that this happens.

RIEGLE REVIEWS HEALTH CARE OPTIONS FOR UNINSURED IN MICHIGAN

Warren, Michigan—U.S. Senator Donald Riegle, chairman of the finance Subcommittee on Health for Families and the Uninsured, held a public hearing today to review options that he is considering for legislation to provide universal access to health care.

Senator Riegle received input from the uninsured, business and government leaders and health care providers. Many of these people attended a public hearing in Southfield last June and were instrumental in helping to define the problem and in formulating the options now under consideration.

Since July, a bipartisan senate working group composed of key senate health policymakers has been meeting in an effort to develop a private—public partnership approach that would enable all Americans to have quality, affordable health care.

"We want to reach out to those who, under the current system, seem to fall between the cracks—including the working uninsured, the unemployed and their dependents," said Riegle. "My top priority is to see that all Americans have health care coverage," he added.

The Senate working group, led by Riegle, will carry on the work of the Pepper Commission which will formally submit its recommendations on the uninsured to Congress on March 1, 1990. The group will then draft legislation under the jurisdiction of the Finance Subcommittee and Labor and Human Resources Committee. The Pepper Commission is charged with studying health care for the uninsured as well as long term health care.

Senator Riegle will use today's testimony on the various options to help finalize legislation.

PREPARED STATEMENT OF ELI E. ROBINSON

Good morning. I am Eli E. Robinson, President of the Southfield, Michigan City Council and I am going to speak about the concerns that we as municipal officials have about health care and hospitals in particular.

First, let me tell you about our city. We have a resident population of 82,000 which increases to 260,000 during the daytime. One-fourth of our residents are senior citizens. We have 22 million square feet of office space which makes us, I have been told, the third largest office center in the midwest. Our city covers 26 square miles, is intersected by two major expressways and shares a common border with Detroit, which is our neighbor to the south.

Everytime I go to another meeting or seminar or hearing I wind up asking myself the same questions at the beginning and the end of the session: Why are we here? What have we accomplished other than to take time and space?

Those of us from the municipal government side are probably closest to the needs and quality of life of our residents. And for too many years we may have taken too much for granted. We assumed that the only barrier to obtaining adequate health care was an economic one at the level of the individual: if you could afford it, it would be there. Certainly the technology was there. The reality of the situation is now that due to financial instability many of the hospitals in our area simply may not be there to provide services regardless of the economic ability of the individual.

We have seen numerous state and Federal commissions appointed to study the problems. And study they do. But produce nothing. We feel that time is of the essence and that there is sufficient blame to go around. The institutions have been guilty of poor business practices while their finances have been strained by high operating costs and low revenues. Medicare Medicaid simply do not provide the necessary cushions to cover the unreimbursed and unpaid care provided to the indigent. Insurance carriers and governmental payers have been guilty of delayed and underpayment practices. State and county budgets are already badly strained. Individuals have been guilty of use and abuse of the hospital facilities, especially emergency rooms, as opposed to the utilization of other first-line lower-level care providers. There Is also current pending state and Federal legislation that would strain the resources of the hospitals even further.

This isn't a political, a racial or a geographic problem. This is a problem for all of us. We in the suburbs are not apart from the problem of the inner-city hospitals. If any of the hospitals fail, what will happen to the others? Will the remainder be overwhelmed by the economics of the situation? Is there going to be a financial domino effect?

Every day and in every part of this country we read about the horror stories of emergency rooms being temporarily closed to ambulances enroute and critical patients dying because of the delay. In Southfield our excellent emergency medical service has an average response time of 3.6 minutes. But to where will the patient be taken if the emergency rooms have closed or the trauma centers are out of existence?

We who are responsible for the quality of life and the health and welfare of our residents cannot simply sit by and criticize or pontificate. And we are not interested in recrimination or retaliation. We certainly have a moral and ethical responsibility to act to prevent this crisis from going any further. We cannot accept these threatened hospital closings. It Is not just peculiar to Southfield, to the metropolitan Detroit area or to the state of Michigan. It Is a national problem. Hospital and trauma care Is as critical a part of environment and Infrastructure as roads, air and water quality, solid waste removal, drug control and other issues that have seized the headlines.

The answer is not just another Federal mandate for all employers to provide health insurance. It is sheer hypocrisy to mandate, take credit for the good deed and then pass the bill on to business who in turn pass it on to the consumers. Even that approach does not provide coverage for certain obvious groups.

The urgent need is for immediate massive financial assistance to stop further erosion of the situation and then the adoption of a stiffly enforced non-partisan uniform national policy to maintain institutional quality and availability including trauma centers and the supporting network of primary health care units.

The urgent need is not for another study by a blue-ribbon commission of learned experts, This is not merely a matter of wanting another playfield or cultural arts center. For our residents this is more: it is the issue of the viability of our cities as a place to live and work if there is no adequate hospital care. This is literally a matter of life and death. The time for debate Is over. In the book of Deuteronomy, chapter 30, verse 19, is recorded the following:

> "I have set before you life and death, blessing and cursing: therefore choose life that both thou and thy seed may live."

We have chosen life.

Prepared Statement of Michael Roush

On behalf of the more than 500,000 small business members of the National Federation of Independent Business (NFIB), I am pleased to participate in this hearing. NFIB commends the Bi-Committee Bi-Partisan Senate Working Group on Universal Access for recognizing the importance of addressing the issue of small business lack of access to affordable health insurance and health care.

NFIB's membership mirrors the national business population in its make-up. This parallelism to the general small business community and our large membership are particularly important as they provide validity to the numerous studies the NFIB Foundation has conducted on the issue of health insurance and small business.

BACKGROUND

Small businesses have always been a dynamic force in the American economy. Millions of Americans own and operate small businesses. Over 19 million Americans report income or losses from business activity. Self-employment is the principal occupation for over 8 million Americans. Of the 10.5 million new jobs created in the past decade, 64O1, were created by small businesses. Small business employs over half of the private sector workforce, and that number continues to grow.

To better understand and evaluate one important public policy area access to health care—NFIB has conducted three comprehensive surveys. These surveys, conducted in 1978, 1986 and 1989, reveal the practices, opinions, and attitudes of small business owners in the area of health insurance benefits. The results are not surprising to those who understand small business. Unfortunately, the data clearly indicates that small businesses are encountering serious market difficulties which cannot be easily addressed by public policymaker.

ACCESS FOR SMALL BUSINESS

Small business owners aide the victims of a two-tiered problem: first, rising health care inflation and second, rising health insurance premiums, or the unavailability of insurance. Both have one common element—cost. Cost restricts the access of small businesses and individuals to the health care system. Without affordable insurance premiums or affordable health care many people are unable to provide adequately for their health needs.

The most recent figure on the uninsured claims that 31.8 million individuals are uninsured.[1] The breakdown of this population is illustrative. It suggests that there are distinct subsets, each requiring different tactical approaches to ensure health care coverage. A focus upon uninsured workers misses substantial portions of the uninsured population, e.g. unemployed, low-income, and children.

For small businesses and their employees, access is determined by cost.[2] Cost most likely explains a recent observation—the slight decline in the number of small firms offering health insurance as a fringe benefit.[3] Cost prevents new firms from offering health insurance [4] and jeopardizes the continuation of existing health insurance benefits.[5]

The cost of health insurance can be the greatest payroll line-item cost in a small business—many times exceeding the combined cost of workers compensation and liability insurance.[6] Exacerbating the problem, a majority of small firms pay 100% of the premium cost. These same businesses have little access to managed care or cost-containment measures. In addition, small firms are unable to obtain the benefits of self-insurance [7] and therefore must comply with expensive state-mandated benefit laws,[8] pay state premium taxes, and shoulder a larger portion of the carrier's administrative expenses.[9]

Two thirds of small businesses offer health insurance.[16] In general these firms tend to be more mature, more profitable, and have more full-time employees than their counterparts that do not offer health insurance. Despite being fairly stable, these small firms experience high initial premiums and higher renewal premiums. Frequently cited reasons for the high cost of health insurance for small firms include:

- insurer fear of adverse selection
- instability of the firm
- lack of expert help in choosing plans [17]

- little negotiating clout
- strict experience rating
- nature of the small business workforce:
  - (a) labor intensive
  - (b) high percentage of part-time employees [18]
  - (c) high percentage of older workers
  - (d) high percentage of very young workers
  - (e) more remedial workers
  - (f) high turnover
- high administrative costs for the carrier
- insufficient experience data
- absence of preferential treatment afforded to larger firms
- imposition of state premium taxes

For those not offering health insurance, the following factors have been consistently identified as the most common inherent barriers to offering health insurance: [19]

- Cost of premiums or past increases too great
- Insufficient profits
- Insufficient cash flow
- Employee turnover too great
- Too many employees covered elsewhere—secondary wage earners
- Too many part-time employees
- Too many older employees
- Employees prefer cash compensation
- Too small to receive group "discounts"
- No suitable cost-containment options available [20]

The above "inherent" factors coupled with the currently fractured marketplace, result in limited availability of health insurance for small business.

Small business owners are becoming extremely frustrated.[10] Small business owners believe that every American has a right to health care.[11] Small business owners also desire to offer health insurance as a fringe benefit out of both a sense of familial obligation,[12] and competitive necessity.[13] However, the reality of 20 to 300% premium increases, a low profit margin,[14] struggling regional economies, and restricted cash flow impairs the business' ability to purchase health insurance.[15]

The causes of the cost crisis can be divided into four subcategories: reneging on government obligations; government-erected barriers to offering health insurance; medical inflation; and insurance industry practices. Factored into the equation are variables unique to the small business community that make small businesses especially vulnerable to the workings of this disjointed marketplace.

NFIB believes that the issues of cost and access are indivisible.[21] Universal access to either insurance or medical care hinges upon both being affordable to the purchaser.

To address the issue of the uninsured, NFIB has developed a strategy to attack the rapidly increasing health insurance premiums charged to small firms. The strategy encompasses the principal contributors to the current crisis. It aims at returning the business of insurance to the "law of large numbers" and restoring a competitive marketplace. It is NFIB' position that the cost crisis stems in part from the interplay between severe fragmentation of the marketplace, provider practices, and government-erected barriers.

The "Access for Small Business" strategy is outlined below. The objectives of the strategy are to improve access through affordable health insurance and cost-effective quality medical care. This strategy represents a combination of cost containment mechanisms, removal of cost increasing government barriers, and changes in insurance underwriting—each prong, however, depends upon the others for success. *Brief* descriptions are provided.

ACCESS FOR SMALL BUSINESS STRATEGY

I. Federal Government Obligations. In at least four separate areas, the Federal Government has avoided express obligations.

(1) *Medicaid.* Medicaid is no longer a safety net for low income individuals. Medicaid should be reformed to ensure that it fully serves its intended population.

(2) *Medicare.* Medicare has had a serious Impact upon the operation of the health care marketplace, including the institutionalization of both cost-plus reimbursement and cost-shifting. Medicare must be redesigned in order to main-

tain its commitment to the elderly and disabled, but also to reduce its impact upon the remaining marketplace.

NFIB does not offer specific recommendations at this time other than to urge legislators to recognize the large, distorting role both Federal programs play in the health care marketplace—over one-third of all U.S. medical expenditures are incurred by these programs.

(3) *Full deduction of health insurance costs for the partnerships, sole proprietorships and S-Corporation business owners. Almost one-half of the business owners in this country are considered "self employed" yet they are discriminated against by the Federal tax code. The owners of these businesses only receive a 25% deduction for their health insurance premium costs, while their incorporated counterparts receive a full 100%.*

It is estimated that I in 6 self-employed business owners are uninsured. A full 100% deduction helps to defray the high cost of premiums and encourages the provision of health insurance to their employees. The premiums of these firms are often the highest in a carrier's portfolio because of the very small size of these businesses.

(4) *COBRA should be repealed as a business obligation.* COBRA acts as an important safety net for former employees. However, the obligation should fall to the state or Federal governments to allow those individuals to buy in to a government-sponsored employee health insurance plan. Further, COBRA requires employers to remain the primary insurer for Medicare-eligible employees and to cover former employees for up to 29 months who are Medicare "wait-listed." Both provisions are budget-driven policy decisions, enacted with little regard to the impact upon premium costs of small firms.[22]

Consistent with the small business belief in fiscal responsibility, the above reforms require a concentration and prioritization of overall Federal effort, rather than an increase in Federal spending.

II. Removal of Barriers.

The insurance marketplace must be leveled to remove the current two-tiered effect. The first step is to close the ERISA loophole that permits self insurance, or in the alternative, to confer upon small firms unable to absorb that risk all of the privileges of self insurance, including a credit for state premium taxes paid and "community-rated' premiums. NFIB believes that the best marketplace is one where all businesses are participating, regardless of size or wealth. Additional changes include:

- *Preemption of state health insurance mandates* to permit the offering of "barebones" polices There is consensus in the business and insurance communities that such mandates significantly increase the cost of health insurance for non self-insured businesses. "Barebones" policies are appealing to the segment of the business community that is currently unable to offer health insurance. Mandate-free policies immediately lower the cost of health insurance for all non self-insured firms by a minimum of 20%.[23]
- *Preemption of laws which restrict the formation of HMOs,* managed care, METs, and other cost containment mechanisms.
- *Simplification* or reinstatement of the following tax code provisions:

  (a) *Cafeteria plans* (IRC sec. 125) and reformation of regulations regarding rollover and employer liability.

  (b) *Voluntary Employees' Beneficiary Associations* (VEBAs)

  (c) *Multiple Employer Trusts* (METs)

  (d) *Individual line item deduction* or refundable tax credit, on the E-Z 1040, for the cost of health insurance premiums. This deduction or credit could be means tested to ensure direct targeting to low-income individuals or families.

The last item was permitted until 1981. The first four items represented viable options to help small firms manage the cost of health insurance, but are now so complex that few small firms are able to employ these options.

III. Cost containment—hospitals, doctors, and patients.

NFIB believes that reforms in other areas will not be successful until medical inflation is conquered. Attainment of significant cost containment must include, but should not be limited to, the following:

- *Consumer empowerment.* Patients must have information on fees, treatments, and physician practices. Until the patient becomes an active and informed participant, the type and cost of medical care will remain negotiating points only between the provider and the insurance carrier.

- *Return to individual responsibility.*[24] The competitive marketplace will not succeed unless the patient behaves like a consumer and believes that he/she has a responsibility to make good health care decisions.
- *Data.* Outcomes research, provider-developed practice protocols, and hospital ratings are three methods to coalesce and develop information necessary for informed decisionmaking. In addition, such data provide a basis for informed analysis of treatments by providers willing to modify their practices.
- *Wellness education.* The key to controlling future health care expenditures is to promote healthy behaviors and preventive are.
- *Medical malpractice reforms.* The protocols discussed above should be admitted as defenses in a medical malpractice suit.

IV. Insurance Industry Reforms

NFIB believes that if the above reforms are implemented, the insurance industry will be forced to operate in accordance with the "law of large numbers,"rather than fragmenting the marketplace to the detriment of small business. By re-creating a marketplace where all employees are essentially part of the same pool, interim solutions such as risk pools or reinsurance mechanisms become unnecessary. To facilitate this goal underwriting reforms must be implemented immediately.

WORKING GROUP OPTIONS PAPER

Mr. Chairman, we were specifically asked to comment upon the options paper prepared by the Senate Working Group. Let me begin by saying that I hope this group will not rely principally upon outmoded mandate mechanisms to provide access.[29] As I have stated previously, the core problem is the cost of medical care. Others have not address this issue head-on, preferring to focus on the secondary issue of expanding employment-based health insurance.

Cost containment remains the key to this complex puzzle. The high cost of care and insurance is exacerbated by the Federal government's involvement, first dollar coverage, unfettered provider practices, minimal competition, misplaced incentives, a disenfranchised consumer, and the lack of readily available information on procedures, fees, and results. With affordability and competition will come the desired access for employers, employees, and individuals.

Of the options presented in the paper, NFIB members clearly prefer those that are free-market oriented which will at the same time change the status quo.[30] The development of a "barebones" or basic, catastrophic plan is particularly appealing. Our data indicates that there is a market for such a plan. Current pilot projects in Denver (Robert Woods Johnson) and Cincinnati (Ohio Hospital Association) bear out this contention—low cost plans that protect a family against serious financial strains are attractive to small businesses that cannot afford more costly coverage. While such plans usually entail the use of high deductibles to keep the cost low, these deductibles can be "offset" by permitting individuals to put aside pre-tax dollars. Section 125 of the Internal Revenue Code provides such a mechanism, but is so overly complex that few small businesses are able or willing to use the cafeteria medical savings accounts. Changes in the rollover rules, employer liability, and paperwork and administrative requirements would encourage more firms to take advantage of this tool The use of medical savings accounts have two additional benefits: they bring the individual back into the medical decisionmaking process and they encourage individuals to save for immediate and future needs, such as nursing home care.

Even for those small firms that wish to purchase a more comprehensive plan for their employees, the elimination of state mandates will go a long way to reducing costs A recent Wayne State University study found that 16% of those not offering health insurance would have but for the state health insurance mandates.

Many of the proposals contained in the "options paper" represent consensus points among a wide variety of interest groups. The elimination of state mandates and 100% deductibility for the self-employed and S-Corporation business owners are just two examples that business, providers, academics, and possibly labor can agree upon. There are others. Even the health insurance industry has made some remarkable reform-oriented suggestions. It would be relatively simple to package all of these consensus points into a legislative plan. Pass the consensus items, such as those listed in the "Access for Small Business Strategy," and give those reforms time to work. This approach would provide some measure of immediate relief to small business and their employees yet enable the Congress to focus on the more difficult or controversial health care issues.

CONCLUSION

Not unlike other Americans, owners of small businesses seem to be faced with a serious dilemma regarding their values about the provision of health services, the high cost of these services and who has the responsibility for paying the bill for health care. The vast majority of small business owners feel every American has the right to basic health care and most do not disagree with the statement that Americans should receive a minimum level of health care regardless of their ability to pay. Many believe that because of the high cost of health insurance premiums, their firm's marginal profitability position, and their belief that they could not pass on the cost to customers, providing any (or better) health insurance benefits to their employees would not be a wise financial decision.

Incentive based plans, such as employer risk pools or tax-based incentives, may entice some employers to add health insurance plans or expand the ones they now offer. However, in order to induce many of the firms not currently offering a plan into participation, the employers' net cost will have to reduced. Cost again clearly determines the offering or continued offering of health insurance.

Any government policy that mandates small business owners to cover their employees for health insurance is likely to be accompanied by small business failures, changes in business employment policies that are likely to result in higher unemployment levels, and higher product costs to consumers.[30] The effect of a mandated or "disincentive" program appears to be sensitive to the net cost borne by the small business. Because similar health insurance plans are currently more expensive per employee for small businesses than for larger ones, any mandated program would have a penalizing effect on small and new businesses, especially in the service, agriculture, and retail trade sectors.

The solution then lies in a free-market enhancing approach that targets the high cost of medical care and lowers medical inflation. Cost containment coupled with the removal of government barriers and reform of government obligations will help to ensure universal access to quality health care.

ENDNOTES

1. The estimated number of uninsured individuals has ranged from 31 million to 37 million. The number can also be inflated if dependents of workers and/or "underinsured" individuals are added. The concept of "under" insured is subjective.

2. The NFIB Foundation has conducted three comprehensive health surveys: 1978, 1986, and 1989. In addition, in 1983 and 1986, small business owners were asked to rank order 75 issues from liability insurance to garbage collection to taxes. Health insurance was ranked number one. Surprisingly, health insurance even ranked higher than liability insurance (ranked No. 2) at a time when the liability insurance crisis was at its peak (1986).

3. Two thirds of small businesses offer health insurance. Between the first NFIB study (1978) and the second study (1986) the number of small firms offering health insurance increased by 8 percentage points. Between 1986 and 1989, the percentage of small firms declined by less than 2 percentage points. The decline may be within the range of statistical error or may be the indication of a trend. A 1990 follow-up field survey indicates the latter may be operating. These results were confirmed by the ICF study sponsored by the Small Business Administration.

4. "New" refers to both established and start-up firms. While two distinct groups, they share at least two common characteristics—marginality and very limited cash flow. In addition, new firms have no past experience upon which insurance companies can assess the risk.

5. In 1989, over 89% of small business respondents cited the cost of health insurance as becoming "prohibitively expensive." In 1990, 19.7% of firms surveyed without health insurance indicated that health insurance was offered at some time in the past.

6. Between 1987 and 1989, small business health insurance premiums rose from an average of $1942 to an estimated $2646. [Foster & Higgins data].

7. Over 50% of the business community self-insures, and that number has been rapidly increasing since ERISA's passage in the 197Os. Most firms that self insure tend to be large and profitable. Less than 49% of small firms are able to self insure. Self insurance provides at least four benefits: 1) compliance with state mandates is not required; 2) no state premium taxes are assessed; 3) lower administrative costs; and 4) the company has complete flexibility to design the health benefit plan.

8. There are over 690 state-mandated health insurance benefits requiring coverage for everything from chiropractic care to mental health care to in vitro fertilization to payment for herbal medicine treatments. State health insurance mandates drive

up the cost of health insurance for small firms from between 20 to 30%. Larger businesses that can self-insure under ERISA are able to avoid these mandates and design their health plans according to their employees' needs, not as defined by the state government. In addition, state health insurance mandates have been shown to increase medical care inflation by creating an artificial demand for services. The Center for Policy Analysis (Dallas, Texas) estimates that twenty-five percent of the uninsured, both businesses and individuals, are the result of the higher costs created by state health insurance mandates.

9. SBA estimates that large firms receive 95 of benefits for every dollar spent, whereas smaller firms receive 60–75 of benefits for every dollar spent.

10. Sixty-one percent of the respondents in 1989 called for government help in reducing the cost of health care and health insurance. Small businesses also supported the imposition of doctor fee structures in Medicare. However, the majority of small firms oppose national health insurance and an overwhelming majority oppose mandates, strongly believing there are market-oriented "fixes."

11. Sixty-nine percent either agreed or strongly agreed that every American has the right to basic health care regardless of ability to pay.

12. Health insurance is the second most frequently offered benefit in a small firm. The first benefit offered is paid vacation time.

13. In today's shrinking labor market, small firms are intensely competing with both large and small businesses for qualified, skilled employees. A less generous fringe benefit package is a competitive disadvantage which neither attracts nor retains good employees.

14. The median small businesses owner takes out of his/her business less than the median wage and salary worker. About 40% of the 1989 study respondents took out of their business less than $30,000 last year.

15. Small firms are price sensitive. Of those firms not offering health insurance, 28% said they would offer insurance if premium costs were lowered at least 20%.

16. To date, the employee-provided health insurance system has been successful. The number of Americans covered by employment-based insurance has risen from 40% in the 1940s to over 80% in 1989.

17. Small businesses typically engage in "one-stop shopping." One independent insurance agent is used to provide all of the business insurance needs. In addition, there is limited expertise in the small business with respect to benefit design and negotiation. The owner is typically the benefits manager, payroll administer, etc. The average small business owner spends 8 to 10 hours a week on paperwork alone.

18. Small business owners view full-time employees (defined as working over 25 hours a week) as distinct from part-time employees. The limited connection to the workplace and the part-timers' preference for cash compensation or flex time create a difference between the benefits offered the two types of employees. This difference has been institutionalized by the insurance industry, which charges higher premiums for part-timers or refuses to cover such employees.

19. Less than one percent of those not offering health insurance stated that under no condition would health insurance be offered.

20. Less than 4% use HMOs.

21. Cost refers to both the cost of health insurance and the cost of medical care.

22. NFIB MANDATE vote: 92% oppose the requirement to provide health insurance to former employees. (5% undecided, 3% favor) and 53% favor complete repeal of COBRA (14% undecided, 33% against)

23. MANDATE vote: 90% of small business owners oppose state-mandated health insurance benefit laws.

24. The 1989 survey clearly showed that small business owners believe that access to health care or health insurance was a right; however, they strongly believe that it is the individual's obligation to purchase care or insurance, not the employer's responsibility.

25. MANDATE vote: 89% oppose mandated health benefits (4% undecided, 7% favor).

26. MANDATE vote: 94% oppose "pay or play" schemes (2% undecided, 4% favor).

27. MANDATE vote: 60% oppose risk pools (18% undecided, 22% favor).

28. MANDATE vote: 78% oppose a national health insurance program (6% undecided, 16% favor). This is currently being repolled.

29. Among those small firms not currently offering an employee plan, less than half say they would expect to stay in business as an employer under a mandated program which required a one-hundred dollar per month per full-time employee insurance premium. Over one-fifth of the total small businesses indicated that under

the above described mandated plan they would either lay-off all their employees or would discontinue operations entirely.

30. 1989 SURVEY SUMMARY: Sixty-three percent of responding small business owners to the 1989 study reported that they sponsor a health insurance plan to at least some of their employees. Thirty-eight percent sponsored a plan to all their employees. The remainder, about 34 percent, offered no employee health insurance plan. Older and larger firms were more likely to have sponsored a plan and firms in rural areas were less likely to provide employee health insurance benefits. Firms engaged in manufacturing or wholesale business activities were most likely and retail trade and service related firms least likely to offer a plan. Owners that reported using a large percentage of part-time employees and/or employees that owners believed not to be a head of a household were less likely than other firms to sponsor an employee health insurance plan. Prospective employees interest in health insurance benefits as reported by the owner and the knowledge that the firm's major competitor offered an employee health insurance plan seems to have had an encouraging affect on influencing owners to offer health insurance benefits. Finally, owners' attitudes about the importance of providing health insurance benefits as an employer responsibility and as a means to attract good employees seem to be influential in determining which firms do and do not sponsor health insurance.

APPENDIX I.—SMALL BUSINESS AND HEALTH SOURCE: SMALL BUSINESS ADMINISTRATION

The small business employee profile:

- Young
- Unmarried
- With the employer less than one year
- Prefers wage compensation
- 20% of the small business workforce are part-time employees (compare to: I 3% of the large business labor force)
- 20% turnover rate among small businesses (compare to: 15% turnover in large businesses)
- 40% small business employees eligible for health insurance coverage. (compare to: 25% large business employees)
- 14% of workers in firms under 25 employees turn down health insurance coverage. (compare to: 7% in large firms)

The Uninsured Profile:

- 31 million uninsured
- 8.2 million private wage and salary workers
- 1.6 million business owners, mainly self-employed, sole proprietorship and partnership owners
- 23% earn more than $30,000 a year

Small Business Coverage Profile

- ⅔rds of all small businesses offer health insurance Firms typically are more profitable, high number of full-time employees, larger.

Firm size	Percent not offering coverage
1-9	54
10-24	22
25-99	8
100-499	2

Costs—those that do not provide health insurance:

Hypothetical $80 per month per employee = 20% of profits
Hypothetical $125 per month per employee = 30% of profits

Gallup poll: Number one problem in the health care area is COST.

NFIB Problems and priorities: Number one general business problem is COST OF HEALTH INSURANCE.

APPENDIX 2—ACCESS FOR SMALL BUSINESS STRATEGY—SUMMARY

OBJECTIVE: To improve access through affordable health insurance and cost-effective quality medical care.

I. Renewal of Federal Government Obligations

A. Medicaid reforms
B. Medicare reforms
C. 100% deduction for the self-employed, sole proprietorship, partnership, or 5-Corporation business owner
D. COBRA reform and transference

II. Removal of Government Barriers

A. Pre-emption of state health insurance mandates
B. Pre-emption of state managed care or HMO restrictions
C. Simplification of:
1. Cafeteria plans
2. VEBAs
3. METs
D. Reinstatement of the individual line-item deduction for health insurance premiums.

III. Cost containment

A. Consumer empowerment
[illegible] Outcomes research
[illegible] Physician practices guidelines
D. Wellness education/preventive care promotion
E. Medical malpractice reforms

IV. Insurance Industry

A. Return to the "law of large numbers"
1. Self insurance
2. Interim reinsunance mechanism
B. Underwriting reforms

V. Unacceptable Mechanisms

A. Mandated benefits
B. "Pay or Play" schemes
C. Inequitable competitive schemes
D. Triggers
E. National health insurance

PREPARED STATEMENT OF VERNON K. SMITH

I am Vern Smith, Policy Director for the Michigan Medicaid Program. I also serve as Director of the Michigan Health Care Access Project, and Project Director for the "Healthy Start" Program.

Healthy Start is Governor Blanchard's new initiative to provide health coverage for all children in Michigan who live in families with incomes below 200% of the poverty line. The first phase of Healthy Start is to begin on October 1, 1990 with coverage for children up to age 10.

Healthy Start is one of the products of Governor Blanchard's Task Force on Access to Health Care. That Task Force looked at one set of national data on the uninsured which I found to be compelling.[1]

- The uninsured are less healthy; they are one-third more likely to be described as being in fair or poor health.
- Yet, despite apparent greater need for medical services, the uninsured are less likely to receive them. In fact,

—an uninsured person is 19% less likely to be admitted to a hospital
—an uninsured adult is 27% less likely to be seen by a physician
—an uninsured child is 34% less likely to be seen by a physician.

The Task Force commissioned a special survey, the Health Insurance survey of Michigan, and found parallel results for this state. That survey also focused on children without health insurance. We found there to be 264,000 uninsured Michigan children, about 30% of the total number of persons uninsured in Michigan.

---

[1] Robert Blendon, Harvard School of Public Health, reporting on the 1986 Robert Wood Johnson Foundation/UCLA national survey results.

We also found that:

- about ¾ of uninsured Michigan children are in households with incomes below 200 of poverty
- about ⅔ of uninsured children live in households where the head is employed full-time
- about ½ of uninsured children live in a household where the head is employed in a business employing less than 10 people
- over half of the uninsured children are under age 10.

Clearly, a focus and priority on children is warranted. As Governor Blanchard said in his State of the State message last month:

> "Our children deserve a healthy start in life. Without good health, no child can grow up to lead a productive- fulfillin9 life, nor can we expect to have a competitive workforce for the future if we do not invest in our children's health now. Therefore, no child should be without adequate health care."

Accordingly, we urge you and your colleagues in the U.S. Congress to take such action as will assure health coverage for all, but especially for children. We particularly urge you to advocate for flexibility in defining state Medicaid eligibility limits, so a state such as Michigan which may choose to extend eligibility to age 18 and 200 of poverty may do so.

HEALTH CARE ACCESS PROJECT

In addition to a public program approach such as healthy Start, any successful strategy must also maximize private health insurance coverage. The Health Care Access project experience is quite instructive on this issue.

The Health Care Access project (HCAP) is a too-county demonstration project which is now in its third year.

There are two parts to HCAP. The first is a health benefit for persons on general assistance who can't qualify for Medicaid.

The second part is a public subsidy of private health insurance. This part is called the "0ne-Third-Share Plan," because it pays one-third of the actual cost of health insurance premiums when a business which hasn't offered health coverage before begins to offer it. And, the employer and employee each also pay a one-third share.

There are some important insights from our HCAP experience. Allow me to list three conclusions which we have drawn:

1. Most employers who don't already offer health coverage will not voluntarily respond to subsidies or similar incentives to initiate employer-based health insurance if the incentive only covers one-third the cost of health coverage. The HCAP experience is that almost 200 businesses did respond by initiating health coverage. These businesses are of every type, from restaurants to body shops, florists to professional offices. But, these businesses represented less than 14% of the 1,700 businesses who were contacted and were offered the chance to participate.

2. Qualified businesses which chose not to participate in the HCAP 0ne-Third-Share Plan almost exclusively cited cost as the reason.

The HCAP experience suggests there is a real need for more affordable health coverage.

Health insurance represents such a large cost that many small businesses simply cannot afford it.

And what is worse, health insurance for small businesses is more expensive than it is for larger businesses—typically ⅓ more costly for exactly the same coverage.

In fact, the employer's cost of health insurance in Michigan in 1988 was 63% more than the combined cost of workers compensations employment insurance and the single business tax.

3. Health Insurance is a higher priority for employees than for employers.

Among the businesses participating in HCAP, there is almost universal participation by employees. Only a handful of employees chose not to enroll when offered the chance by their employers, and every one of them were the stereotypical "young invulnerable," i.e., males under the age of 25.

4. Many employees in businesses without employer-based insurance are in fact insured.

We were surprised at first to find that only about 60% of employees in businesses that began offering coverage under HCAP were signing up for insurance coverage.

When we checked, we found that 40% of the employees in these businesses were already insured as a dependent through a plan offered by another employer.

Clearly, businesses that offer health coverage, whether they are large or small, are significantly subsidizing businesses that do not offer health coverage.

There is more than one kind of cost shift in health care, and the cost shift from businesses that do not offer a health benefit to those that do is one that is often overlooked.

Let me conclude with this.

Three weeks ago, a Mr. Richard Sandstrom of Marquette, Michigan wrote a letter to the Marquette County Department of Social services, from which I want to read two paragraphs.

> "It has been almost a year since my first cancer operation and I write this to say I'm doing well and to say thank you. Without your assistance and the HCAP (Health Care Access) Program, a traumatic experience could have been much worse. I work part-time and am going to school (just graduated from N.M.U.) and with no insurance (unaffordable) when this illness struck, I was literally worrying myself sick—which is no way to cure cancer.
>
> Now, as I heal and recover, with very little of the burden of the expense hanging over me, I can get on with my life. Had these major expenses been weighing me down through school and recovery, there is no doubt that I would have become despondent and possibly dropped out."

Nor is Mr. Sandstrom an isolated case. His oncology social worker at Marquette General Hospital, Patti Hanold, Indicates that in her experience:

> "Many young cancer patients who do not have insurance coverage "fall between the cracks" in the present system, because they are not disabled for a long enough period of time to qualify for Medicaid . . .
>
> "Oncology patients represent only a portion of the rising members of uninsured Americans who face a real need for medical treatment and who have no means to pay for the expensive care and treatment which is required."

In America, this is not the way the system should work. We need a system of universal health care which will cover all of the Mr. Sandstroms, as well as all of the children, and the pregnant women, the moms and dads employed in small businesses, the unemployed, Americans one and all.

We applaud you, Senator, in your efforts to attack this issue. We are prepared to assist in any way we can.

Thank you.

PREPARED STATEMENT OF GAIL R. WILENSKY

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss health care cost containment strategies and the uninsured. cost containment strategies are an integral part of our mutual effort to assure Americans access to affordable, high quality health care. The Medicare and Medicaid programs have had significant experience with various approaches to restraining expenditure growth while maintaining or enhancing quality. I am happy to share that experience with you today. I also want to offer what I believe are logical and prudent approaches to getting better value and better care for the health care dollars we spend.

Allow me to begin my remarks by addressing our common concern for providing access to health care for the nation's uninsured.

THE UNINSURED

This Administration remains committed to expanding access to health services for America's most vulnerable families.

As you know, the quadrennial Advisory council on Social Security will make recommendations on access to health care to Secretary Sullivan this Summer. In addition, last Fall the Secretary directed the Under Secretary to lead an HHS Task Force charged with exploring solutions to the access problem. I am pleased to serve as Vice-Chair of this Departmental Task Force. The President, in his State of the Union address, further elevated the priority of this issue by requesting that the Secretary guide a Domestic Policy council review of studies on the quality, accessibility, and cost of our nation's health care system. This review will draw on the work being done by the Department's Task Force.

These efforts underscore the Administration's highest-level commitment to marshalling the leadership, energy, and expertise necessary to address an issue that touches so many Americans. It is not an easy or quick process. currently, we are reviewing the many dimensions of this multi-faceted problem. Once information is digested, we can proceed with crafting our recommendations. It would be premature and, indeed, impossible to forecast the outcome of these efforts. But, I look forward to sharing with you the results of the Administration's exploration in the future.

While we search for viable solutions to the problem of the uninsured, HCFA remains committed to implementing programs under current law that help ensure access. Through the Department's Maternal and Infant Health Initiative, we encourage states to offer Medicaid coverage of pregnant women and infants up to 185 percent of the Federal poverty line. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is also a valuable Medicaid benefit for our nation's children. The EPSDT benefit requires states to provide screening, dental, vision, and hearing services. It allows states to provide any service for which Federal matching funds are available, regardless of whether the services are usually covered under the state's Medicaid plan. HCFA will continue to seek input from all interested parties, including the American Academy of Pediatrics and the Children's Defense Fund, as we implement OBPA 1989 provisions expanding EPSDT. HCFA is also coordinating its efforts in this area with our colleagues in the Public Health Service (PHS) to ensure that the HCFA and PHS programs which serve the poor are well coordinated. Initiatives to improve communication within the Department and with groups in the private sector are increasingly important to us.

COST CONTAINMENT DEFINED

Financial pressures of the current health care environment force us to rethink our concept of cost containment. The strategies we relied on in the past have been a useful starting point. But, they are not adequate to control ever-increasing health care expenditures in the future. We must look toward more systematic approaches to cost containment—approaches that provide consumers, hospitals, and physicians with positive and appropriate incentives for controlling costs.

How do we do that? We must focus our broad cost containment efforts on *securing better value for our health care dollar. Better value means improved access to high quality care. Better value means ensuring that the care provided has been proven effective. Better value means eliminating unnecessary services. And importantly, better value means communicating with informed consumers and creating sound alliances with the providers of health care services.*

COST CONTAINMENT STRATEGIES

Since the inception of the Medicare and Medicaid programs, the Federal government has worked to ensure that public funds pay only for necessary and appropriate services. But, this has become an increasingly difficult job in the complex environment of today's health care marketplace. Still, our experience has highlighted several strategies that hold great potential for cost containment.

In any discussion of cost containment, one underlying principle we must remember is that incentives to provide effective and efficient care do work. The health care community reacts positively to incentives. We must foster an atmosphere that permits these forces to work. But, we cannot create such an environment if we micromanage our health care system or burden it with overly prescriptive regulations. Instead, we must foster innovation and inspire creative solutions.

Coordinated Care

One approach we believe holds great promise is "coordinated care." Coordinated systems of care encompass a wide variety of delivery arrangements such as health maintenance organizations (HM0s) and preferred provider organizations (PPOs) These systems operate in a competitive environment, prompting the efficient management of health care resources. In short, coordinated care promotes *better value and better care,* both for the elderly and the poor. Many Medicare beneficiaries have multiple chronic conditions that require the services of several physicians. Coordinating their care helps avert problems such as duplicate services and the prescription of contra-indicated drugs by different physicians. For Medicaid recipients, coordinated care approaches mean access to a more extensive range of services than traditional fee-for-service. In short, coordinated care is a better use of our scarce resources.

The Administration is committed to prepaid, managed health care. HMOs and similar managed care plans have demonstrated their ability to provide high quality care at an affordable price. We are particularly encouraged by the steady growth of both Medicare and Medicaid enrollment in prepaid health care plans. currently, nearly 2 million Medicare beneficiaries and about 2.5 million Medicaid recipients are enrolled in prepaid health plans.

Proposals to. encourage managed care are a cornerstone of the President's FY 1991 Medicare and Medicaid proposals. Our FY 1991 proposals provide incentives for consumers to enter coordinated systems of care and for health care plans to participate in Medicare and Medicaid. Our proposals would provide more flexibility to states that enroll Medicaid recipients in HMOs and more Federal funds for these enrollees. We also propose paying HMOs more for each Medicare beneficiary enrolled.

We want to adopt a private sector innovation in the delivery of coordinated care: the preferred provider organization (PPO) PPOs will provide Medicare beneficiaries another option in health care—one that consumers in the private sector have enjoyed for years. Our proposal would link managed care networks with supplemental insurance to provide Medicare "wrap around" coverage. Beneficiaries who enroll would benefit from reduced premiums, coordination of services, and extra billing protection. This approach is consistent with trends in employer coverage. Insurers could use managed care networks developed for their employer-based group business in their private Medigap business.

Effectiveness of Medical Practice

The desire to derive maximum value for each health care dollar invested is the primary motivation for pursuing medical treatment effectiveness research. When we have sound scientific evidence that the medical treatments we purchase yield favorable outcomes, and that those treatments are being appropriately performed on the individuals who could benefit from them, we will have constructed a health services delivery system that best serves the people it is designed to help.

To advance research in this area, the Department is pursuing an initiative designed to explore the effectiveness of medical practice through outcomes research and the development of medical practice guidelines. As HCFA Administrator, I serve as Vice-Chair of the Intra-Departmental committee for the Medical Treatment Effectiveness Program. While the effectiveness initiative may give rise to program savings over the long term, its true value lies in its potential to enhance the *quality* of American medicine. It will help us know that the investments we make in health care are necessary and appropriate. Given that the current health care environment is characterized by limited resources and that we are committed to ensuring quality care, such *accountability* is critical.

Other Cost Containment Strategies

Innovation—often the key to our future—is most likely to occur in a competitive environment. We can learn much from the successes of the private sector in finding more efficient ways to deliver health care. While we cultivate such innovations as coordinated systems of care, it is also important to support and encourage other cost containment mechanisms that foster competition in the health marketplace. Allow me to briefly mention several cost containment activities that we are currently pursuing.

Bundling Payments: Particularly in the Medicare program, we want to expand the current practice of bundling payments for certain physicians' services. Making a single payment for an episode of care moves the health care system further away from a la carte medicine. This is a positive trend. Importantly, bundling focuses the responsibility for coordinating care on *providers* of health care services.

Through a HCFA demonstration project, we are currently examining the feasibility and cost effectiveness of a negotiated package price for coronary artery bypass graft surgery. Hospitals and physicians participating in the demonstration will receive a global payment covering hospital and physicians' services related to the surgery. We look forward to implementing the demonstration in the Fall of 1990.

Selective Contracting and Competitive Bidding: Selective contracting is a cost containment strategy developed in the private sector. I believe it can also be a very worthwhile innovation for public programs to pursue. Several states are selectively contracting with hospitals to provide care to Medicaid recipients. Selective contracting is, essentially, a form of competitive bidding that provides states and hospitals financial incentives to provide a better value for Medicaid dollars. Recent reports show that these programs have reduced spending without impairing access to or the quality of hospital care. California reports an estimated savings of $299 million in

1988–1989. Illinois saved about $84 million during 1985–1986, its first year of selective contracting.

State Medicaid programs also use volume purchasing arrangements and competitive bidding to purchase optical services, vaccines, and prescription drugs. All of these programs have reported substantial savings.

It's time to evaluate the potential for greater use of such arrangements in public programs. The fiscal crisis that impelled States to undertake selective contracting and competitive bidding continues at both the State and Federal level. A thoughtful assessment of how and where to implement further competitive strategies seems essential at this point.

Payment Reforms: Payment reforms are perhaps the most visible cost containment strategy. For example, the Medicare Prospective Payment System (PPS) was implemented in 1983 with the expectation that it would moderate Medicare expenditures for inpatient hospital services. By most accounts, PPS has been successful. Indeed, many states have adopted prospective payment systems under Medicaid.

At this juncture, allow me to mention that HCFA is proceeding with plans to fold hospital capital costs into PPS beginning October 1, 1991. The current cost-based system provides fuel for wasteful duplication of capital and unnecessary adoption of expensive technologies. We believe that incorporating capital into PPS provides hospitals with a better incentive to make prudent capital decisions.

Medicare physician payment reform is another example of how payment reforms can create more appropriate incentives. The Medicare fee schedule will refocus the current incentives in Medicare physician payments by generally increasing payments for primary care and reducing payments for surgery and other procedurally intense services. At the same time, the Medicare Volume Performance Standard will be helpful in restraining overall costs for Medicare physicians' services.

Payment Safeguards and Peer Review: Payment safeguard activities such as medical review, provider audits, and assuring compliance with Medicare secondary payor requirements have provided substantial savings of program funds. Peer review activities, including utilization review, second surgical opinions, and pre-admission screening are useful in avoiding unnecessary procedures. Importantly, such mechanisms also serve as an educational tool for providers practicing outside the norm.

Beneficiary Cost-Sharing: Beneficiary cost-sharing is another strategy which can be helpful in controlling overall expenditures. Since its inception, Medicare has required beneficiary cost-sharing including coinsurance, deductibles, and Part B premiums. About 25 State Medicaid programs also impose nominal co-payments on Medicaid recipients. The challenge associated with beneficiary cost-sharing is ensuring that cost-sharing requirements do not impose an excessive financial burden on beneficiaries, or discourage them from seeking necessary health care.

CONCLUSION

The viability of any proposal to enhance access will depend on the extent to which it can keep costs under control in the long term. I am eager to work with you as we develop cost containment strategies for the future.

I would be pleased to answer any questions you may have.

Prepared Statement of Gary W. Woodbury

My name is Gary M. Woodbury and I am the president of the Small Business Association of Michigan, or, as we call it, SBAM. We are a statewide trade association representing nearly 4,000 small businesses throughout Michigan.

SBAM supports efforts to improve the availability and affordability of health care for all of Michigan's citizens. We have a long history of representing the interests of small business on health care issues and we are pleased to be given the opportunity to be here today. —

I'd like to give you a brief outline of the positions taken by SBAM as it relates to access to health care:

(1) SBAM believes that access to health care is vital to all Michigan citizens.

(2) SBAM supports the enactment of tax-based incentives to encourage small group health insurance and cafeteria benefit plans.

(3) SBAM promotes the participation of employers, employees, providers and third-parry payers in any effective management of health care and health insurance costs.

(4) SBAM strongly opposes government attempts to mandate insurance benefits, treatments and coverages which add administrative costs and fail to resolve the problems of access to health care and stem the rising costs of our health care system.

(5) SBAM recommends allowing NII deductibility of health insurance premiums for nonincorporated businesses and reforming insurance laws to promote small group availability. Government should also encourage insurance companies, HMOs, PPOs and other health service deliverers to develop flexible and creative programs for small employers.

(6) SBAM supports taking steps to reduce regulatory obstacles which make small group plans less available and affordable.

There is no question that rising health care costs have become a problem for all of Michigan's employers. Over the last ten years, spending in Michigan for health services has risen 261 percent. In 1988 alone, Michigan employers spent $6.7 billion to provide health care for employees. This amount is 63 percent *greater* than the $4.1 billion combined expense to Michigan employers for Workers Compensation, Unemployment Insurance and the Single Business Tax.

Add to that the fact that health insurance is much more costly for small businesses. In Michigan a fully-insured small employer of fewer than 10 employees can expect to pay premiums up to 50 percent greater than those paid by self-insured employers with more than 500 employees for comparable benefits.

Because their relative costs for health coverage is higher than that paid by large businesses, Michigan's smaller employers find themselves at a competitive disadvantage.

Because they cannot afford to buy the kind of health insurance potential employees expect, small employers also are at a disadvantage in recruiting their labor force.

And, again because of their size, smaller firms are unable to take advantage of measures used by larger enterprises to reduce health care costs.

SBAM believes that the one of the keys to unlocking the door to greater health care access is in aiding and encouraging, not mandating, small businesses in offering health insurance to their employees.

I know of no small business owner who does not want to provide health insurance to his or her employees. I know of many who cannot afford to do so. By making such insurance more affordable for employers, employers will make it more available to employees.

There is a direct correlation between how large a company is, how long a company has been in business and how a company is organized and what health plans a company offers its employees.

The larger a company is and the longer it has been in business, the more likely it is to offer health benefits to its employees. This is logical since both size and longevity are somewhat indicative of economic wellbeing. The money is there to pay for employee health benefits. Conversely, the newest firms and the smallest firms are often operating on a tight budget and cannot afford health care coverage.

The company's organizational structure also makes a difference in offering health care coverage. Corporations and Subchapter S corporations are more likely to offer health insurance than sole proprietorships. And again, this is logical since a corporation can deduct 100 percent of its health insurance payments while a sole proprietorship can only deduct 25 percent of these payments.

SBAM has long supported the idea of tax credits and/or premium deductibility as a method of improving not only availability but affordability (and I emphasize affordability) of health care coverage. If the goal is to have more small businesses offer health insurance, then health insurance must be made more affordable.

Attempts to force small employers to offer health insurance through "tax disincentives" such as those used in Massachusetts will not solve the access problem. They will, in the long run, only make the problem worse.

What then will help?

We believe Senator that many of the measures you have outlined will help to solve the problem of access to health care.

Positive modification of the tax code to encourage and assist private employer coverage is a step in the right direction.

Subsidies for start-up businesses and insurance market reform which will allow employers to choose insurance packages which meet the basic need of their employees are other steps which can be taken.

An aggressive cost containment program is also vital to improving access to health care.

As you know Senator, the Governor's Task Force on Access to Health Care will be issuing its final report in late March or early May. SBAM served as a member of that task force and we believe that its recommendations will help serve as a focal point for actions both in Lansing and in Washington.

Senator Riegle, I want to thank you again for the opportunity to appear before you today and assure that the Small Business Association of Michigan stands ready to work with you to help assure health care access for all of the state's citizens.

PREPARED STATEMENT OF ROBERT J. YELLAN

Good morning. My name is Robert Yellan, and I am the vice president for governmental affairs for the Detroit Medical Center. The DMC is a health care system which includes seven hospitals which form the academic health center for Wayne State University. Five of our hospital facilities are located in central Detroit, one in northwest Detroit and one in Western Oakland County.

I am pleased to provide our views to the Senate Finance Subcommittee on Health for Families and the Uninsured, and I am most pleased that one of our own Senators is chairing the subcommittee; this gives those of us in Michigan the opportunity to have our perspectives presented to the subcommittee in a very direct way.

We have been asked today to give our views, as the largest provider of care to the uninsured in Michigan, on an outline of options prepared by the subcommittee, designed to provide "Health Care for all Americans." The title itself is an important statement. a document called "Education for all Americans," or "Highways for all Americans," or even "Retirement Benefits for all Americans" would not signal a need for a change in our basic public policies; but "Health Care for all Americans" would reflect a major change in our current system of providing health care access and coverage.

Our current system, which is unique among the nations of the world, is made up of a collection of public and private health care coverage programs. While there are inefficiencies in this model, it reflects our basic American tendencies toward pluralism and most Americans are comfortable with it. A pluralistic system can accomplish the goal of providing access to health care for all Americans, but only if there is an adequate program within which everybody fits. The problem we face is that our pluralistic system has resulted in major gaps in assuring health care for all Americans. An estimated 37 million Americans, nearly one million of whom live in Michigan, have no source of health care coverage, and many millions more have coverage inadequate to meet their basic health care needs.

We have allowed ourselves to close our eyes to this situation for a long time by a variety of complex cross-subsidies through which health care providers, especially hospitals, have been the de facto insurer of last resort for those who are not fortunate enough to have a job which provides adequate health care benefits, or who are not considered "deserving" by our historical social safety net.

While some communities may "get by" with this system for a few more years, in the Detroit area, and in many of our nation'sother major metropolitan areas, this system is rapidly falling into a crisis.

The DMC is projecting that in 1990 it will provide over $65 million in uncompensated care—care to those without public or private coverage, and without the resources to pay for their care. And this does not include the uncompensated care provided by our physicians. Uncompensated care accounts for approximately 6,500 of all care delivered by our hospitals, and represents a 38% increase in the past two years alone. provision of uncompensated care is a major contributor, along with underpayment from existing public programs, to three consecutive years of significant operating losses reaching $35 million in 1989. the fact is that neither we nor other major hospitals in metropolitan Detroit are in a position to continue to be that insurer of last resort.

What insights can our experience bring to bear on the preliminary options set out by the subcommittee?

First, the vast majority of our hospital uncompensated care results from non-pregnant adult patients between the ages of 21 and 64, who are not permanently disabled and who have limited financial resources. this is the result of two factors:

- Michigan has been a leader in providing coverage for pregnant women and young children through the Medicaid program, and other state-sponsored programs. Virtually all pregnant women and young children in households with incomes less than 200% of the poverty level now have access to coverage.
- the Medicaid program's reliance on categorical eligibility requirements have left major gaps even among the poorest of our nation.

Thus, we believe the highest priority of any solution to the problem of the uninsured is the establishment of a new public program (or a restructuring of Medicaid) which provides "payor of last resort" coverage based solely on income, without regard to categorical restrictions or relationship to the public assistance system. At a minimum, this program should initially provide coverage for those below 100% of the poverty level, with a phasein to higher income levels with consideration of cost-sharing provisions based on ability to pay.

A second lesson we have learned from the DMC experience is that approximately 50% of our uncompensated care is provided on an outpatient basis, either in the emergency departments of our hospitals or in our outpatient clinics. much of this care is of a routine nature, treatable in virtually any primary care physician's office. The problem is that these people have no source of primary care, because of a shortage of primary care physicians in the inner-city and because those physicians who do serve the inner-city are unwilling and unable to provide care to this population. The fact is, because of low payment rates and bureaucratic paperwork, and the enormous burden of malpractice insurance in southeastern Michigan, most private physicians are not accepting new Medicaid patients, let alone those patients with no source of payment. Thus, we believe that any program to address the uninsured must provide coverage for a broad range of physician diagnostic and treatment services, and must assure payment levels, particularly for primary care, which enable the covered population to receive care in the least costly setting.

The third lesson we can bring from our experience is a recognition of the role of substance abuse, violence and other reflections of our societal ills as contributing factors in the growth in and cost of uncompensated care. Approximately half of the uncompensated care provided by our system is delivered at Detroit receiving hospital and university health center, one of the few hospitals in the nation dedicated to the provision of emergency and trauma care. Through its doors come the victims of gunshots and stabbings, motor vehicle accidents resulting from alcohol abuse, medical consequences of illegal drug use, rape, and those suffering the effects of poverty, homelessness, and poor nutrition. any comprehensive approach to dealing with the problems of the uninsured must recognize that a simultaneous effort must be made to reduce these underlying causes of illness and disease.

Next, we have learned some administrative lessons through experience with the Medicaid program. While state administration has enabled the tailoring of Medicaid to the political and health care environment of each state, there is little question in our minds that states have had too much flexibility with respect to coverage, benefits, and payment systems. In our view, coverage under any new public program must have uniform coverage requirements for all states, consistent minimum benefit packages and provisions which prohibit what we have experienced in Michigan with regard to payment policies. To be more specific, incremental improvements and expansion in the program cannot be allowed to be financed by decreasing payments to providers. It does us no good to receive payments for those who are currently uninsured and have payments for those who are currently covered reduced by the same or even larger magnitude.

I turn now from the public program options to those dealing with the private sector. A comprehensive solution to health care for the uninsured cannot rest solely on public program improvements. Clearly many of the patients we serve who contribute to our uncompensated care burden are employed on at least a part time or intermittent basis, or in low-paying jobs without health insurance as a benefit of employment. We believe that the time has come to consider mandating of a basic level of health insurance for those who are employed, by requiring employers to purchase coverage directly or to pay into a public fund to provide coverage. We further believe that this requirement must be imposed at the federal level in order to avoid competitive business climate impact among states.

This is not, as some would suggest, a revolutionary concept. Our nation has for many years mandated retirement benefits, workers' compensation benefits, and unemployment insurance through employers. The problems created by employees without health care coverage will continue to grow as our economy grows from a manufacturing base to a service sector base where employee health care benefits have traditionally been less than adequate.

But it is also clear that we cannot approach mandatory coverage in a cavalier manner which ignores the burdens that such a policy would place on small businesses. We support the use of the tax code or other financial mechanisms to relieve the burdens on small business, in order to assure health care benefits for those in the work force and their dependents. careful utilization of cost sharing, co-payments and deductibles should also be permitted in order to reduce the financial burdens on small businesses, but in a manner which does not impede the appropriate use of needed health care services.

Lastly, we recognize that any comprehensive approach to the uninsured must be coupled with reasonable measures to help control the overall costs of health care. The option paper identifies a number of approaches which in concept are supportable and necessary, including promotion of managed care, evaluation of the cost effectiveness of medical treatment, incentives for the rational elimination of excess system capacity, and medical liability insurance reform.

On behalf of the DMC, I appreciate the opportunity to have shared our views with this subcommittee, and look forward to working with Senator Riegle as efforts continue to address this important social policy problem.

COMMUNICATIONS

STATEMENT OF THE AETNA LIFE INSURANCE COMPANY

The focus of this statement is health care cost and the role that managed care systems can play in helping to contain that cost, while assuring that individuals receive quality health care. It is submitted on behalf of The Prudential Insurance Company of America, CIGNA Corporation, Metropolitan Life Insurance Company, Aetna Life Insurance Company, and The Travelers Companies. These five companies, collectively, provided health benefits protection through network-based managed care programs to over 10 mill ion Americans in 1989. These benefits are provided through more than 350 networks, including some 335,000 providers.

The American health care system is a unique blend of public and private financing and delivery mechanisms, and its strength comes from its diversity. Our private sector approach provides flexibility and innovation in both the financing and delivery of health care. For the continued success and improvement of the health care system, it is essential that the role of the private sector be maintained. A health care system operated or financed entirely by government or under its sole control would ultimately diminish the quality of care and potentially restrict access, as experienced in Canada and Great Britain with the rationing of services.

There are serious weaknesses in the present system: insufficient mechanisms and incentives to stimulate efficiency; the absence of a coordinated system for delivering care; the failure to finance coverage for all Americans; and a concentration of resources on highly intensive acute care to the detriment of basic health care needs. These can best be overcome by a fundamental change in policy focus.

As the Congress undertakes its deliberations on improving access to health care, we believe it is critical that there is a consideration of the entire structure of the health care delivery and financing system. An increase in Federally funded benefits without a fundamental change in the system for providing care will inflate the cost of the system, and ultimately lead to a further reduction in the access to and quality of health care. Access can best be improved by introducing a more rational method of financing and delivery which will make coverage more affordable. Specifically, we believe that health care financing and delivery should be organized around managed care systems, operated by a variety of private sponsors, serving both public and private beneficiaries.

The insurance companies submitting this statement are placing greatly increased emphasis on developing, marketing, and operating plans which provide managed care services. By this term we refer to a plan which arranges with providers to furnish health care services to its members; has explicit standards for the selection of the providers who provide the health care; has organizational arrangements for an ongoing quality assurance and utilization review program for the care provided by its selected providers; and, in certain plans, gives patients the opportunity to choose, when they need care, whether to use the providers selected by the plan or non-plan providers, with financial incentives to use plan providers.

Managed care is winning increasing acceptance in the marketplace. More than 32,000,000 Americans now receive their care through some type of HMO; membership in HMO plans has tripled just since 1981. Many more Americans benefit from other forms of managed care. In just two years managed care plans have grown from 41% of the market to 71%. Fee-for-service plans that manage care have increased from 18% to 37% of the market. Programs permitting patients to choose, at the time treatment is needed, whether to use plan providers or to go outside the plan have increased from 9% to 16% of the market. And HMOs have increased their share of the market from 14% to 18%. When the Congress considers the nature of the private health care insurance market, it should not think of it only as traditional, fee-for-service, indemnity insurance; the market is rapidly moving toward managed care systems.

The managed care community is committed to refining its management techniques and improving its marketing to win greater acceptance of managed care. We encourage the Finance Committee to consider legislation that would pre-empt state laws that pose unreasonable legal barriers to the operation of managed care plans. Such action would greatly enhance our efforts to promote managed care programs and assure beneficiaries access to reasonably priced, quality health care.

THE ELEMENTS OF MANAGED CARE

We have strongly held opinions concerning the kinds of managed care plans that will be most effective over the long term in providing quality care at reasonable cost. However, at this stage in the evolution of the concept and development of the market, managed care should not be encased in a definitional straitjacket. Although traditional HMOs continue to be the most popular and proven form of managed care, the field should be encouraged to experiment with different systems and to compete to determine which are most effective and can win market acceptance. The sponsors of managed care must provide products that meet the demands of employers and their workers and evolve to meet changing demands. This competition has led to the development of new products that are more flexible than the traditional HMO, but more structured than the conventional indemnity plan. We are continuing to develop new concepts of managed care and new understandings of what it can accomplish.

Effective managed care plans, however, do share, in varying degrees, certain attributes. They furnish a comprehensive range of services through a network of participating providers. They organize and integrate the resources devoted to providing care, from primary care to highly specialized institutional services, and assure the delivery, or deliver to the patient, the most appropriate level and type of care. They implement guidelines and protocols developed by medical experts for determining appropriate care, which participating providers agree to follow. To the extent possible, providers are selected to participate on the basis of the quality of the care they provide and the efficiency with which they function. Our practice is to continually monitor the performance of participating providers. Standards are developed for recruiting providers, and to assess performance, based on training, professional credentials, and results. Agreements with providers implement utilization standards and payment mechanisms that create incentives for the appropriate and cost effective provision of care. To make those agreements effective, managed care plans also provide incentives for members of the plan to use the participating providers. Clearly, not all managed care plans fully incorporate all of these provisions at the current time, but many already do and all successful plans ultimately will include all of these provisions.

Because of the flexibility in the types of managed care offered, employers and their workers can determine which elements of managed care they want. Although these techniques are more effective when they are implemented in a coordinated manner through operational arrangements with participating providers, they can be used to advantage in indemnity plans as well. We have found that employees initially are reluctant to join plans which may not include every provider. However, as they become accustomed to using the providers selected by the plan, and see the quality and cost benefits derived from doing so, they tend to phase into plans offering more rigorous management of care.

THE BENEFITS OF MANAGED CARE

Appropriate care

Managed care provides the patient an easy and known entry point into the health care system at the most appropriate level, not through a hospital emergency room but through a primary care physician or other outpatient facility. It provides the patient professional assistance in determining the appropriate modalities of care and the appropriate provider, and it provides a continuum of integrated care with followup that providers who are not tied to a managed care system cannot perform.

More recently, many managed care plans are combining the benefit of a structured plan with the ability of patients to select their own physician. By giving the patient in these plans a point of service choice at the time treatment is needed, a member of a plan can choose between the providers selected by the plan and non-participating providers on the basis of quality and cost. To maximize the plan's benefit, an incentive is provided to the patient to use a participating provider. Typically, the plan will require a greater copayment if the patient uses a non-plan provider. But the patient has the choice, and has it at the most relevant time. This feature makes managed care more acceptable to employees than plans which have no mechanism for out-of-plan care and provide no assistance when a member uses a nonplan provider.

Quality

Quality in a managed care environment will be vastly improved as compared to traditional insurance plans that simply pay claims. In a managed care environment quality is monitored and improved by a formalized process that addresses the qualifications of providers and the appropriateness of care furnished. All of our companies are making a major commitment to the development of technologies necessary to select cost efficient, quality providers of care and help to assure the outcomes of treatment for our patients.

Care is reviewed to ensure that it is delivered in accordance with the guidelines and standards developed by medical authorities. Treatments are avoided which the most current medical research shows are not proven to be efficacious. Managed care requires providers to consider the way they provide care in light of new learning and professionally developed guidelines, and avoids over-utilization. The quality of care received by patients is enhanced; patients are not subjected to unnecessary or inappropriate modalities of treatment. The judgment of the best medical authorities is made available to individual patients' care-givers.

Contrary to the belief that utilization review impedes care, quality is monitored and enhanced by requiring prior approval for certain services, concurrent review during a hospital stay, and retrospective review of services to identify possible over- or under-utilization in a completed course of treatment. Case management is employed so the patient receives the most appropriate modality of service. Frequently, a physician serving as a primary care gatekeeper is charged with the responsibility to oversee the medical services furnished to the patients for which he or she is responsible. The assurance of the quality of care being provided is a key component of managed care plans and is often the basis upon which companies compete.

Cost effectiveness

Managed care arrangements are intrinsically structured to be cost effective. By avoiding over-utilization and matching patients with the appropriate level and situs of care, managed care is able to provide better care at a lower cost. A customary technique for cost containment in traditional insurance plans is to increase the copayments which covered employees must pay when they receive care. This shifts some of the risk to the employee, but does not give him/her the expertise or the bargaining power, and in fact even little incentive, to be a cost-effective purchaser of care. Managed care plans provide the needed cost-saving mechanism by their selection of providers and management of care, without requiring greater out-of-pocket copayment by employees.

More research is necessary to fully document the savings, but recent empirical evidence suggests the extent of the advantage of managed care. Group practice HMOs and IPAs in the years 1987 and 1988 were able to hold the rate of increase in premiums charged to employers to one-half that of conventional, indemnity insurance plans.

Flexibility

Managed care plans can achieve by negotiations, driven by market forces, what government fiat cannot. Managed care plans can negotiate utilization and fee requirements with providers which are acceptable to providers. Managed care plans can implement these flexibly and locally. Most importantly, managed care plans in a competitive market must always operate for the best interest of the patient. Managed care is the vehicle by which quality, efficiency, and customer satisfaction come together in a competitive marketplace. The patient is better served by such an arrangement than by the unilateral actions of government dictated by budget pressures.

Increased access for the uninsured

Access to health care can best be expanded when the mechanisms for efficient, cost-effective delivery of care are in place. By constraining costs, managed care plans make the expansion of benefits to others more feasible. As managed care matures and is able to exercise its cost-constraining muscle, the system-wide increases in the cost of health care will be moderated, and coverage will be more affordable for everyone. As health care is provided more efficiently, it will be possible to provide more coverage to more beneficiaries, and to do so with less risk of further inflating health care costs.

One of the characteristics of managed care programs is that those individuals who are the sickest can realize the most benefit from managed care through case management. The techniques of managed care can constrain the cost of covering the high risk population and provide more appropriate care for them. If combined with reform of small case insurance underwriting and marketing practices, and the establishment of a privately financed reinsurance mechanism, coverage would be more widely available and affordable.

What needs to be done

Increased attention today is being given to developing the techniques of managed care. Managed care has expanded beyond its based of traditional HMOs; providers, employers, traditional insurance companies, and sponsors of IPAs, PPOs, and new forms of HMOs are adopting managed care and developing new techniques. Building upon the studies of the past decade, a widespread and vigorous effort is being made to define, measure, and evaluate the appropriateness of particular procedures, to develop guidelines for care, and to fashion the best ways to put them into practice. Intensive efforts are underway to develop a variety of new management techniques. What is needed is the time, the policy atmosphere, and the legal framework for managed care to develop further.

Continued development and expansion of managed care will be fostered by:

1. An explicit recognition that managed care is an important vehicle for organizing the health care delivery system; and a commitment to use managed care more extensively and effectively in government programs.

2. Identification of institutional and legal barriers which prevent managed care from fulfilling its full potential. Legislation overriding these barriers would assist greatly the continued expansion and effectiveness of managed care. Managed care is threatened by laws that:

- Restrict the ability of third party payors to negotiate reimbursement rates with providers and require them to reimburse providers their reasonable, customary, and necessary charge determined by the providers; these laws would restrict the ability of managed care plans to develop more cost effective care.
- Require a managed care plan to pay the same fees to providers who are included in its system as those who are not; these destroy the incentives necessary to develop a managed care system and undermine its purpose.
- Restrict the rights of sponsors of managed care plans to contract selectively with a limited number of providers; these prevent managed care plans from obtaining the best and most cost conscious providers.
- Restrict the ability of plans to utilize primary care physicians; these restrictions limit plans' ability to ensure that appropriate and cost-effective treatment is provided.
- Limit the copayment that a managed care plan may require a beneficiary to pay if he uses a non-plan provider; these undermine the ability of a plan to give sufficient incentive to patients to use the network of cost-effective providers.
- Prohibit utilization review of certain treatments or conditions; these prohibitions gut a critical element of managed care.
- Require utilization review decisions to be made by residents of the state in which the treatment is offered; these make it difficult for national companies to participate in the local market and add unnecessary costs.

Federal preemption of such laws and of laws which mandate the coverage that must be provided would give managed care a better opportunity to provide cost-effective, quality care.

We believe that a consensus is developing that managed care offers the best vehicle for providing high quality, cost-efficient, health care. Any legislation developed to enhance access to health care should recognize the role that managed care systems can play. We recommend that managed care plans be encouraged as a mainstream vehicle for financing and providing care and that barriers to the further development of managed care, such as those we have outlined in this testimony, be avoided.

Statement of

American Psychiatric Association
American Psychological Association
National Alliance for the Mentally Ill
Mental Health Law Project
National Association of State Mental Health Program Directors
National Mental Health Association
National Council of Community Mental Health Centers

Thank you, Mr. Chairman and Members, for the opportunity to submit testimony to the Pepper Commission on the special needs of people with mental illness for acute health care coverage.

This testimony is offered on behalf of a coalition on national organizations of mental health professionals, providers, advocates and consumers who have long been concerned about the failure of our health care system to provide the basic elements of acute care services to people in need of mental health services. The organizations which have endorsed this testimony are:

American Psychiatric Association
American Psychological Association
Mental Health Law Project
National Alliance for the Mentally Ill
National Association of State Mental Health Program Directors
National Council of Community Mental Health Centers
National Mental Health Association

The testimony reflects the general position of the Associations listed above. Individual associations may also submit separate statements addressing more specific issues. Our statement discusses the acute care needs of our population. Earlier, on October 6, we presented testimony addressing the long-term care needs of people who are functionally impaired by mental disorders.

I. Current Inadequate Coverage of Mental Health Services

A. Private Health Insurance

Obviously, the 37 million Americans without public or private health coverage have protection against neither physical or mental illness. And, among the 153 million people with private insurance plans in 1986, the access problems for people in need of mental health services is far more difficult than for those seeking physical health care. [1]

o Although 99 percent of individuals and their families had coverage for inpatient mental health treatment, only 37 percent had the same coverage as for treatment of other illnesses. Over 60 percent had either fewer days of coverage or a special annual or lifetime dollar maximum for mental illness. Further, the coverage in 1986 represented a deterioration from 1981 when 58% of persons with health insurance had equal impatient mental and non-mental health coverage.

o Only a small percentage (10.7%) of all participants were covered for partial hospital (day or night) treatment.

o For outpatient benefits, the coverage limitations were even more stringent. While 97 percent of persons with private health insurance had coverage for outpatient mental health benefits, only 6 percent had coverage equivalent to coverage for other illnesses. In general, multiple limits existed on number of visits covered (33%), total dollars reimbursable (68%), and/or percentage of allowable charge paid (48%)

o For many participants, the cutpatient dollar limits were severe. For example, only 24% of the plans reimbursed at higher than 50% of allowable charges. For participants in plans with annual dollar limits, over 77% had payment limits of $1,000 or less per year. While a majority of plans provided over thirty outpatient visits per year, when combined with limits on payment per visit and/or maximum annual reimbursement, combined

o Many private plans have "pre-existing" condition limitations or exclude "conditions not amenable to short-term therapy."[2]

In sum, inpatient and outpatient benefits in private insurance for mental illness are far less comprehensive than those for physical illness. Maximum benefits are lower, deductibles and co-insurance higher and the percentage reimbursed substantially smaller.

B. Public Health Programs

The two national programs providing access to mental health services are Medicare and Medicaid. Each covers a specific and limited segment of the population and neither provides comprehensive service coverage.

The Medicare program contains a number of special limitations relating to mental health services. Part A of the program contains a life-time limit of 190 days of care in a psychiatric hospital. Care in a psychiatric ward of a general hospital, however, is subject to the same limits as any other admission for non-mental health care. Part B limits reimbursement for outpatient mental health services to $1,100 per year, but only if the patient has incurred expenses of $2,200. (The program "recognizes" 62.5 percent of reasonable charges or $1,375 and pays 80% of the recognized amount. The 1989 OBRA, as passed by the House and reported by the Senate Finance Committee, would eliminate the $1,100 cap.) The service may be provided in an individual practitioner's office or as part of an organized care setting such as a community mental health center. Part B also covers partial hospitalization services when provided as part of the program of an accredited hospital. The program will also pay for services "incident to" a physician's service and reasonable and necessary for the diagnosis and treatment of the patient's condition.

In addition to almost everyone over age 65, persons with disabilities who have been on the SSDI roles for over two years are eligible for Medicare. An estimated 15 to 20 percent of the 2.8 million "workers" receiving SSDI benefits are classified as having "mental, psychoneurotic and personality disorders."[3]

Services for persons with mental illness through the Medicaid program defies easy generalization. We can say that overall the program includes less than 45 percent of all persons below poverty and that its full potential for services to mentally ill people has nowhere been achieved.[4] While the Medicaid program will reimburse states for a broad range of services, few take advantage of options available in the law to provide rehabilitation, personal care or case management services. States have discovered "legal" means to limit even the mandatory hospital inpatient and physician benefits for persons with mental illness. In addition, under the law persons between ages 22 and 64 are not eligible for inpatient services in an institution for mental diseases (IMD) defined as a hospital, nursing home or other institution of more than 16 beds primarily engaged in care, treatment or diagnosis of persons with mental diseases. Although such patients would be eligible for services in the psychiatric ward of a general hospital. In almost all states the mandatory outpatient hospital and optional clinic services have become the principal settings for provision of outpatient mental health services. Almost every state covers prescription drugs, including psychoactive drugs. In all states payments for services are below market rates creating a significant disincentive for many hospitals, physicians and other mental health professionals to treat Medicaid patients.

II. Scope and Prevalence of Mental Illness

The lack of comprehensive or, in many instances, even adequate mental health coverage needs to be juxtaposed against the scope and prevalence of mental illness or mental disorders in the United States, particularly among the working age population.

o In any six month period, approximately 29.4 million adult Americans (18.7 percent of the population) suffer from one or more mental disorders ranging from mild to serious, but for whom therapeutic intervention is appropriate.

o People aged 25 to 44, people in their prime working years, accounted for the largest percentage of admissions to inpatient psychiatric settings.

o Suicides by persons under age 35 was the third leading cause of death for this age group in 1982 and between 1958 and 1982, the number more than doubled.

o The locus and nature of mental health care has changed markedly over the 14 years from 1970 to 1984. Inpatient beds per 100,000 people decreased 57 percent, but inpatient treatment episodes decreased only 7 percent, indicative of significantly shorter inpatient stays. Concomitantly, outpatient care per 100,000 population in organized care settings (i.e. excluding patients served by private practitioners), increased over 135 percent during the same period.[5]

o In 1980, total expenditures for mental health care were estimated to be between $19.4 and $24.1 billion, representing about 8 percent of all expenditures for health care.

III. Principles for Mental Health Benefits in Health Insurance Programs.

Regardless of the specific scope or range of services ultimately recommended by the Commission, we believe that any health insurance proposal should be guided by the following principles.

A. Coverage of All Conditions - In light of the need for mental health services and shortcomings in existing coverage summarized above, the undersigned associations insist that mental health benefits must be an integral part of any set of recommendations addressing access to health care for the American people. Mental illness can be as debilitating as physical illness. Researchers at the Rand Corporation, for example, found that depressed people are as limited in their day-to-day functioning as those with a serious heart condition and even more limited than those with other major chronic disease such as lung or gastrointestinal problems, angina, hypertension or diabetes.[6] Accordingly, there is no basis to distinguish between physical and mental illness in terms of access, eligibility, and coverage.

B. Cost Containment - We recognize that any health insurance proposal adopted by the Commission must include cost containment measures. At the same time the Commission should ensure that the drive to curb spiraling costs is not at the expense of quality care or by excluding certain types of care. Cost containment alternatives for mental health services are discussed in greater detail below.

C. Comparability Between Public and Private Health Plans - The Commission should adopt a proposal which provides for equivalent coverage and reimbursement in both private and public health insurance plans. It is time to end the two-class health care system that exist now between private health care and Medicaid.

D. Spreading the Cost - Individuals, employers, and government should all contribute to a program which ensures access to health care for all. The undersigned organizations believe that the Commission should adopt a plan that fairly distributes the cost of a comprehensive health care program to all participants, except those unable to pay, in the system. Moreover, the lack of insurance and underinsurance for health services afflicts Americans regardless of age. We believe that any health insurance proposal should provide coverage for people of all ages.

E. Preexisting Conditions - No insurance carrier should be allowed to exclude people from coverage because of preexisting health conditions. Too often, carriers have used the presence of a pre-existing condition to deny both coverage and reimbursement for mental illness and many other chronic disorders and conditions. In fact, some insurers will deny coverage to persons who have a history of treatment for mental disabilities. We urge the Commission to recommend a prohibition on this practice.

F. Professional/Provider Policy - Different mental illnesses are amenable to an array of treatment alternatives by a range of mental health providers practicing within the scope of their licenses. The eligible mental health professional for the Commission's proposal should be determined by state licensure and professional practice laws or certification by national accreditation bodies. Both public and private organized care settings as well as individual practitioners should be eligible to provide services. We believe that consumers, including those who receive services through a panel or other form of managed care, should have access to a broad range of mental health providers.

IV. Comprehensive Services

A comprehensive range of mental health services should be available, both to adults and children. Such services should include acute care services for those with a range of mental and emotional problems as well as comprehensive services for individuals with long-term, serious mental illnesses.

For adults, the range of appropriate services would include the following:

o Inpatient care in public or private general or psychiatric hospitals: Reimbursement should be only for patients who receive "active treatment" services (not custodial care)as now required in the Medicare program.[7] If the Commission includes limitations on the number of covered days for mental and non-mental inpatient care, we urge that the Commission also provide for the extension of coverage through peer review of the medical necessity for further hospitalization.

o Partial hospitalization: Day (or night) treatment services furnished through either a hospital or a qualified free-standing program. Partial hospitalization is an intensive ambulatory treatment service offering less than 24-hours-a day care. The program is particularly appropriate for persons with serious mental disorders who are able to maintain themselves in the community. If the Commission's proposal limits inpatient days, there should be provision for a trade-off between inpatient care and partial hospitalization. The determination of the number of partial hospitalization services equaling one day of inpatient care can be established through actuarial analysis of the relative costs of the two modes of treatment. The availability of a trade-off would encourage the use of the least restrictive treatment setting based on the medical needs of the patient. Medicare currently includes partial hospitalization as a benefit for individuals with mental illness, but without provision for a trade-off against inpatient days.

o **Psychosocial rehabilitation:** A program of rehabilitative services focusing on the development of independent living and vocational skills and which provide supportive social programs including peer support. Psychosocial rehabilitation programs have been shown to be cost-effective in providing community care to adults with serious mental illness.[8]

o **Psychopharmacologic drugs:** Coverage of outpatient prescription drugs often essential to stabilizing and treating persons with mental illness.

o **Outpatient treatment:** A broad range of services provided by eligible mental health professionals which includes: assessment and diagnosis, emergency services and crisis care, individual, group and family psychotherapy, medical management of the mental disorder,[3] prescription of medication and medication monitoring. The eligible professionals should be determined by state licensure and professional practice laws or certification by national accreditation bodies. Both public and private organized care settings as well as individual practitioners should be eligible to provide services. We believe that consumers, including those who receive services through a panel or other form of managed care, should have access to a broad range of mental health providers.

o **Case management:** As appropriate, each individual with a serious mental illness should have receive case management services to help insure that an adequate treatment plan is developed and implemented and that services are coordinated.

For children, the range of appropriate services would be similar to those for adults, and would, in addition, include the following services:

o Inpatient care services in residential treatment centers (as well as hospitals).

o Day treatment: similar to partial hospitalization, but involving collaboration or at least close coordination of mental health treatment and education components.

o Early identification, assessment and intervention services

o Intensive in-home services

o Therapeutic foster care and therapeutic group homes

Other components of a complete package include cost sharing provisions and protection against catastrophic costs.

o Cost-sharing provisions: all copayment and deductible amounts and percentages for mental health benefits should be consistent with those required for other benefits in the Commission's recommendations. (We object to the discriminatory provision in the Kennedy-Waxman bill[10] which requires 50% copayment for outpatient mental health services, but 20% or less for other covered services.

o Catastrophic cost protection: Protection against the catastrophic costs of illness -- costs that can wipe out a family's savings and hope for future economic well-being -- is a vital ingredient of any insurance proposal. However, if a limited package of covered benefits are included for persons with mental illness, the "catastrophic protection" must be carefully designed to be workable. The approach adopted in the Kennedy-Waxman bill will not work.[11] It sets a $3,000 ceiling on out-of-pocket expenses based on the out-of pocket costs of "items and services provided under the plan." Under that approach, the catastrophic protection would not apply to mental health cost incurred after the covered services have been exhausted. For example, the cost of 46th day of hospital care would not be included within the calculation of the $3,000 limit.

To partially rectify this problem, we recommend that the Commission, assuming limited benefits are recommended, permit an individual or family to add the costs of uncovered mental health services to otherwise eligible out-of-pocket expenses in determining the catastrophic limit. While this change would not solve the basic problem, it would permit a family with high mental health care costs to reach the cap faster and limit their financial exposure for non-mental health services covered under the plan.

V. Cost Containment

Mental health consumers, providers and advocates are well aware of the governments' and payors' need to ensure that benefits are delivered in the most cost efficient manner. Affordability is a major issue for us all.

Mental health services, more so than for other illnesses, are labor intensive. Therefore, the most effective way to keep care affordable is to ensure that only necessary services are delivered. Fundamental to appropriate utilization of these services is the provision of a comprehensive or balanced system of services. Inpatient hospitalization is by far the most expensive mental health service but is often the only one emphasized under private or public benefit plans. All too often, people with mental illness whose condition may require partial hospitalization or short-term crisis stabilization in the community must be hospitalized simply because they have exhausted their outpatient coverage. A comprehensive benefit package allows the application of both prior authorization and concurrent review mechanisms which assess individual patient needs and base placement decisions upon these assessed needs.

Well developed clinical assessment tools are now widely employed by large private sector payors which accurately assess individual clinical needs and allow for a reliable determination of the least restrictive, clinically appropriate treatment environment for the individual. The purpose of these mechanism is to establish whether the patient is ill enough to justify hospitalization, and while in the hospital, to ensure the patient is receiving the active treatment necessary for the diagnosed condition(s).

We urge that any restructured mental health benefit proposal include a system for prior authorization (except in emergencies) and concurrent and retrospective utilization review for inpatient services. Such a system may also be appropriate for patients who, after initial diagnosis and treatment, are prescribed long-term outpatient services. Prior authorization systems are now widely used by private payors for a variety of illnesses and are not used in an exclusive or discriminatory manner for mental illnesses. Many private payors employing such mechanisms report substantial savings in their mental health expenditures after implementing these mechanisms.[12] Such savings occur principally through reductions in the utilization of inpatient services.

Prospective payment for inpatient mental health care has been researched throughout the 1980's in an attempt to identify which patient characteristics are predictive of the need and utilization of hospital resources. Unlike many acute illnesses, a diagnosis of mental illness alone is a poor predictor of the need for hospitalization. Recent services research on mental illness has focused on other patient characteristics which have a higher predictive value of the need for hospitalization.[13] Our groups strongly support continuing investigations into predictors of hospital utilization and are optimistic that a patient classification system can be developed that will allow for the application of a prospective payment mechanism.

VI. Minimum Mental Health Benefits

Several health insurance proposals considered by Congress the last few years recognize the importance of mental health coverage and include at least minimum mental health benefits. The Basic Health Benefits For All Americans Act (S 768 and HR 1845) ordered reported by the Senate Committee on Labor and Human

Resources and pending before the House Committee on Energy and Commerce contains provisions for inpatient and outpatient mental health services. USA Health (HR 2980) sponsored by Rep. Roybal and presented to the Commission at the October 24th Hearing likewise covers mental health services. Finally, 26 states have legislated coverage of mental health services in the private health insurance plans offered in their state.[14]

We recognize that the Commission, because of cost considerations, may have to recommend a package of minimum benefits as a first step toward comprehensive coverage. To assist the Commission, we suggest, but do not endorse, the mental health services included in the Kennedy-Waxman bill. It would truly meet the definition of "minimum benefits."

Conclusion

The problems faced by Americans in obtaining adequate and affordable health insurance for their physical health needs are also faced by individuals with mental illness. Further, people with mental illness have the additional obstacles of inaccessibility of services, discrimination in coverage policy, and historic emphasis upon the public psychiatric hospital as the primary locus of care.

Our statement has emphasized three responses to these structural problems: comparability, parity and balance.

o Public and private insurance coverage needs to be made comparable at a reasonable level of benefits, not the lowest common denominator.

o Coverage of physical and mental illness must be based on the principal of parity, so that discrimination in coverage against mental health services is ended.

o Coverage must include an array of mental health benefits so that care in not tilted toward one setting, e. g. the hospital, but is balanced by the availability of community based, non-inpatient services.

We look forward to working with the Commission and its staff as you develop specific recommendations for the Congress. Thank you.

ENDNOTES

[1]. The data in this section is adapted from The Coverage Catalog, 2d edition, prepared by the Office of Economic Affairs of the American Psychiatric Association, American Psychiatric Press, Inc. 1989. It utilizes data from the 1986 Employee Benefits Survey conducted by the Bureau of Labor Statistics, as well as APA survey of 300 employer-sponsored benefit plans and Health Maintenance Organizations (HMO) in 1987 and the Federal Employees Health Benefits Program (FEHB) for 1989.

[2]. Plan for Kaiser Permanente, Mid-Atlantic Region, quoted in The Coverage Catalog. p.173.

[3]. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. 1989 edition, WMCP: 101-4, p. 59. The data indicates that about 11 percent of all new disabled worker beneficiaries between the years 1970 to 1982 were mentally impaired. The percentage increased rapidly thereafter rising to 18% in 1985 and 23% and 22% in 1987 and 1988 respectively. Since people with mental illness are likely to be younger when they enter the roles and to have a more normal life expectancy than persons with physical impairments, they make up a growing proportion of the current SSDI population.

[4]. While somewhat dated, the most completed review of Medicaid mental health coverage can be found in Mental Health Benefits Under Medicaid: A survey of the States. January 1984. compiled by Gail Toff for the Intergovernmental Health Policy Project, Washington, D.C.

[5]. Mental Health. United States. 1987, Alcohol, Drug Abuse and Mental Health Administration, #(ADM) 87-1518, 1987, pp 32, 34 and 38..

[6]. Journal of the American Medical Association, Vol. 262, No. 7, August 18, 1989.

[7]. The American Psychological Association supports the language in S 768, Basic Health Benefits for All Americans Act, which provides reimbursement for "inpatient hospital care for a mental disorder."

[8]. Bond, Gary, "An Economic Analysis of Psychosocial Rehabilitation," Hospital and Community Psychiatry, April 1984; and Weltman, Poveromo, Lori and Nofi, Ralph, "Impact of Community-Based Psychosocial Treatment on Clients' Level of Functioning," Hospital and Community Psychiatry, May, 1988.

[9]. Clarification: The American Psychological Association and the National Council of Community Mental Health Centers would substitute "clinical management" for "medical management." The term "clinical management" recognizes that a range of mental health professionals (practicing within the scope of state licensure laws), including physicians, currently provide a variety of services, other than counseling, psychotherapy or diagnostic testing, that form a critical part of mental health treatment plans.

[10]. The Basic Health Benefits for All Americans Act. S768 and HR 1845.

[11]. The American Psychological Association supports the Kennedy Waxman bill, but recognizes the complexity of the catastrophic protection issue.

[12]. Diehr, P., Williams, S.J. and Martin, D.P., "Ambulatory Mental Health Services Utilization in Three Provider Plans," Medical Care, vol. 22, No. 3, March, 1984. Manning, W.and Wells, K. Use of OUtpatient Mental Health Care: Trial of a Prepaid Group Practice versus Fee-for-Service. Rand Corporation, 1985. Rodriquez, A. and Maher, J., "Psychiatric Case Management Offers Cost, Quality Control," Business and Health. 1986. Lee, R. "The Evolution of Managed Mental Health Care," Compensation and Employee Benefits Management. Vol. 5, No. 1, Autumn, 1988. Lee, R. "Employers Address Psychiatric and Substance Abuse Services," Health Span. Vol.3, No. 10, Nov.-Dec., 1986.

[13]. Wood, W. and Beardmore, D., "Prospective Payment for Outpatient Mental Health Services: Evaluation of Diagnosis Related Groups," Community Mental Health Journal, Vol. 22, No. 4, Winter, 1986. Morrison, et. al., A Study of Patient Classification Systems for Prospective Rate-Setting for Medicare Patients in General Hospital Psychiatric Units and Psychiatric Hospitals. Macro Systems, Inc., 1985.

[14]. Taube, Mechanic and Hohman, The Future of Mental Health Services Research. NIMH, 1989.

CRS Report for Congress—Controlling Health Care Costs

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other industrialized nation. U.S. health expenditures in 1987 reached $500 billion, 11.1 percent of GDP, as compared to 8.6 percent in Canada, 6.8 percent in Japan, and 6.1 percent in the United Kingdom.[1] Despite its higher expenditures, the United States performs no better than other industrialized nations, and worse than many, on such measures of health care outcomes as life expectancy or infant mortality rates. These international comparisons have led many observers to conclude that our medical care system is much less efficient than those elsewhere, spending more for less.

Not everyone would agree. Gross measures of health status may reflect, not the relative efficiency of our medical care system, but other differences between the United States and other countries. Life expectancy, for example, may be tied to diet or environment, while infant mortality rates may in part reflect such factors as the rate of teenage pregnancy. Other aspects of quality may not be captured by these measures at all. For example, Americans (or at least insured Americans) may have greater access to advances in medical technology than persons in other countries or may be less likely to have to wait for non-emergency treatment. Assessing the efficiency of the American system depends in part on how one defines quality, a problem that will be considered further at the end of this report.

Whatever the relative quality of American medical care, there are concerns about the rate at which health expenditures are increasing. Inflation in the medical sector has outpaced inflation in the rest of the economy for many years. National health expenditures rose an average of 13 percent a year from 1970 through 1981. The rate of growth declined over the next several years, chiefly because of a decline in inpatient hospital admissions. Between 1984 and 1985 total costs rose just 7.9 percent, the lowest annual rate of increase since the enactment of Medicare and Medicaid in 1965 (though still greater than the growth in GDP). This moderation in expenditure growth proved short-lived. Costs rose 9.8 percent in 1987, and employers and insurers have reported dramatic cost increases over the next 2 years. For example, one recent survey has found that employers' average cost per employee for health benefits rose 19 percent in 1988.[2]

The return of double-digit medical care inflation after a temporary respite has led to concerns that continued growth in medical care costs could impede efforts to improve access to health care and could eventually erode the access that already exists. Many employers have already reduced their contribution to employees' insurance expenses, while the costs of public insurance programs are consuming an increasing share of State and Federal budgets. Proposals to extend coverage to the uninsured have raised concerns that any expansion of the insured population might lend a further impetus to medical care inflation, as did the enactment of Medicare and Medicaid in 1965. While the issue of health care costs and ways of controlling them has been a central one in health policy at least since the early 1970s, these recent developments have given the issue a new urgency.

This report examines policy options for controlling the increase in health care costs by modifying the way medical care is delivered or financed. Most proposals have relied on one of four basic approaches:

- Changing the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care;
- Changing provider behavior through direct modification of medical practice, or by controlling the overall supply of medical resources;
- Changing provider behavior through reimbursement systems that provide incentives for greater efficiency;
- Changing the behavior of both providers and consumers by encouraging consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems.

The remainder of this report provides an overview of the concepts underlying these basic approaches and the evidence available about their ability to achieve savings and their potential impact on access and quality of care. The greatest attention is devoted to the last of the four strategies, competition, because this approach has dominated policy discussion in recent years.

---

[1] Schieber, George J., and Jean-Pierre Poullier. International Health Care expenditure Trends: 1987. *Health Affairs*, v. 8, no. 3, fall 1989. p. 169-177. (Hereafter cited as International Health Care Expenditure Trends: 1987.)

[2] Geisel, Jerry. Health Benefit Tab Rises 19% to New High. *Business Insurance*, Dec. 11, 1989. p. 1.

The report does not consider changes outside the health care delivery system that could directly or indirectly affect medical care expenditures. For example, the incidence of illness or injury might be reduced through public health or health education measures, stronger environmental controls, or improved safety regulation. Changes in the civil litigation system (i.e., malpractice reform) could reduce the practice of "defensive medicine" that is alleged to result in the performance of unnecessary tests or procedures. Such measures might well play an important role in any comprehensive initiative to control medical care spending. They are omitted in order to allow this report to focus more directly on the medical care system itself and on proposals to change the way consumers and providers behave within that system.

COST SHARING

Proposals to hold consumers responsible for more of the costs of their own medical care begin with the premise that comprehensive insurance coverage, largely funded by employers or government, has distorted the health care market by freeing consumers of any need to consider the utility or price of the services they are consuming. While not all observers share the view that growth in health care costs is driven by consumer choices, there are increasing calls for measures to encourage consumers to become more conscious of the price and utility of the medical services they use.

There are two broad ways of doing so. The first is to require consumers to pay a higher share of the premiums for their health care coverage, thus giving them an incentive to choose the most efficiently operated plan. This approach is the subject of the final section of this memorandum. The second method, considered in this section, is to make consumers pay more of the direct costs of the services they use by increasing the deductibles or coinsurance payments required under their insurance plans.

Increases in enrollee cost-sharing responsibility can reduce overall medical expenditures only if they deter some enrollees from obtaining care. Otherwise, they merely shift expenses from the insurer to the consumer.[3] The major study of the impact of cost-sharing on health care utilization and costs was the Health Insurance Experiment (HIE) conducted between 1974 and 1982 by the RAND Corporation, under contract to the Health Care Financing Administration. The HIE randomly assigned 7,700 enrollees to a variety of health insurance plans, including a plan that included no cost-sharing (the "free" plan) and plans requiring coinsurance payments ranging from 25 to 95 percent (subject to overall limits on out-of-pocket expenditures).

The key findings of the HIE were these: [4]

- Cost-sharing reduced the probability that individuals would seek care for any particular medical condition. The strongest deterrent effects occurred among the poor, especially poor children. They were at least 40 percent less likely to obtain care for a given condition than children in the free plan.
- Cost-sharing deterred enrollees from obtaining both "appropriate" and "inappropriate" medical care. Low-income enrollees in the cost sharing plans were less likely to seek care for conditions for which medical care is highly effective, as well as for conditions for which medical care is rarely effective. Those in the cost-sharing plans had worse outcomes for specific conditions (such as hypertension) that can be improved by medical treatment.
- While cost-sharing prevented enrollees from initiating an episode of medical care, it did not change the course of treatment once an individual had entered the medical care system. Within any given episode of care, the cost-sharing enrollees received the same services and medications as other patients.

---

[3] Deductibles have other behavioral effects that may also produce cost savings. Enrollees whose costs during a year exceed the deductible by only a small margin may not go to the trouble of filing a claim. Other enrollees who are careless in record-keeping may be unable to document all of their out-of-pocket expenditures and may therefore spend more than the nominal deductible before the insurance takes over.

[4] This summary is drawn from Lohr, Kathleen, et al. Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial. *Medical Care,* v. 24, no. 9, (Supplement) Sept. 1986. p. 574–577; and Brook, Robert H., et al. Does Free Care Improve Adults' Health?: Results From a Randomized Controlled Trial. *New England Journal of Medicine,* v. 309, no. 23, Dec. 8, 1983. p. 1426–34.

These findings raise several important concerns about the utility of cost-sharing as an approach for reducing medical expenditures. First, as would be expected, its impact is greatest on enrollees with the least income. This effect might be modified by developing cost-sharing requirements that varied by income. Such a system might be administratively cumbersome for employers or insurers. It might also defeat its own purpose, since cost-sharing may not reduce utilization unless it is financially burdensome. (The HIE enrollees in the least burdensome cost-sharing plan actually incurred slightly higher costs than those in the free plan.)

Second, cost-sharing may deter necessary as well as unnecessary care. The goal of making consumers more prudent in their use of health services may demand a degree of sophistication about the value of different services that not all enrollees possess. There have been attempts to develop more carefully targeted cost-sharing systems, to control only inappropriate utilization or to channel utilization in particular ways. For example, a higher co-insurance amount may be imposed for emergency room visits, in order to prevent enrollees from using the emergency room for non-urgent care; this approach is common in health maintenance organizations (HMOs) and has been adopted by some State Medicaid plans. It is not certain, however, that even such narrower measures will deter only unnecessary care.

Finally, and perhaps most important from the perspective of cost reduction, cost-sharing may not modify the course of care once treatment has begun, presumably because the decision-making has generally shifted from the patient to the physician. This finding of the HIE is partly a result of the design of the experiment. Regardless of the level of cost-sharing required, each plan had an out-of-pocket limit, a point beyond which the insurer assumed full responsibility for all further expenses. In the absence of such a limit, enrollees might have been more likely to decline the services ordered by their physicians. At the same time, however, the most severely ill would have been subject to catastrophic financial losses.

Most medical care costs are incurred by a small minority of patients.[5] A cost-sharing system without catastrophic limits will leave that minority unprotected, while a system with limits on out-of-pocket expenses may have a minimal effect on the total costs of care once treatment has been initiated. The problem of controlling the costs of ongoing treatment is the subject of the next section.

CHANGING MEDICAL PRACTICE

Because most medical care purchasing decisions are made by physicians and other providers, rather than by the patients themselves, savings might be achieved if unnecessary services could be eliminated through external review of those decisions or through efforts to modify the providers' own decisionmaking.

External Utilization Controls

The term "utilization controls" embraces a variety of external constraints imposed by a payer on the volume or nature of services furnished or ordered by providers.[6] These include:

- Pre-admission certification for elective inpatient stays;
- Concurrent review, under which patients already admitted to the hospital are monitored to ensure the appropriateness of their continued stay;
- Voluntary or mandatory second opinions before elective surgery;
- Case management, under which the payer or the payer's agent attempts to assume control of the overall delivery of services to an individual high-cost patient;
- Various approaches for shifting the locus of care from high-cost to low-cost settings. These include requirements that certain surgical procedures be performed on an outpatient basis, or that diagnostic tests ordinarily required for inpatients be conducted before the patient is admitted to the hospital.

Utilization controls, especially pre-admission certification and concurrent review, have become a standard feature of health insurance plans during the 1980s. They are now used in the Medicare program, in 29 State Medicaid programs (as of 1987), and in 72 percent of employer-sponsored health plans (as of 1988), up from 59 percent just a year earlier.[7] Despite the rapid adoption of utilization control systems by both public and private payers, they have received little systematic study, and evidence that they actually reduce spending is limited. Pre-admission review has the strongest track record; one controlled study found that it produced net savings for an average employee group of 7.3 percent, with even higher savings for groups that had very high utilization before the programs were initiated.[8] The evidence on some of the other approaches is less clear. For example, some studies have suggested that voluntary second surgical opinion programs may not deter enough unnecessary surgery to offset the costs of the second opinions themselves; mandatory programs appear to be more successful.[9]

---

[5] In 1978, 10 percent of U.S. families accounted for 67 percent of total health expenditures. U.S. Congress. Congressional Budget Office. *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Non-Poor Population.* Washington, U.S. Govt. Print. Off., Dec. 1982. p. xviii.

[6] These techniques are sometimes referred to by health insurers as "managed care." Others restrict the term "managed care" to the more aggressive interventions in the health care system represented by HMOs or similar entities. This is the sense in which the term will be used later in this report.

There are also concerns that even the most successful utilization control approaches focus only on inpatient care and may merely shift the site in which care is delivered without fundamentally changing medical practice.[10] If a reduction in inpatient admissions is followed by an increase in outpatient services, savings may be only temporary; soon costs may begin to rise again as rapidly as before. One observer has argued that, because technologies that were once available only in hospitals are now widely diffused in the community, the hospital is no longer the appropriate focus of cost containment efforts. At the same time, however, utilization controls for ambulatory services have been slow to develop. In part, this is because most ambulatory services have relatively small prices. The administrative costs of reviewing each service may outweigh any potential savings.[11] Some insurers have begun to require prior authorization for the most costly outpatient services, such as CAT scans or other major diagnostic procedures. Whether such measures are actually producing savings is not yet known.

Utilization controls face another barrier that may be even more important than administrative costs: the subjective nature of medical practice. Each patient is somehow unique, and external reviewers may have difficulty overriding the clinical judgments of individual practitioners in specific cases. This may be especially true when there is little consensus about the most appropriate treatment for a given condition, a problem to be discussed in the next section. In any event, some observers have contended that a persistent physician who is prepared to appeal a denial of authorization will often prevail. (The relative leverage of the individual practitioner may have been enhanced by recent legal decisions subjecting external utilization control agents to malpractice liability for denials of necessary care.) In consequence utilization review may function as a delaying tactic rather than an absolute control, achieving savings only because some physicians will not take the trouble to protest the reviewers' decisions. The result has been termed "rationing by inconvenience." [12] Such savings as are achieved may diminish over time as physicians become more skillful in dealing with the system.

For this reason, some analysts have suggested that savings over a longer term may depend on the extent to which providers "sign on" to the concept of eliminating unnecessary services. In this view, real utilization control will require voluntary changes in the way physicians practice medicine

Modifying Practice Styles

Beginning in the 1970s, studies by Wennberg and others showed that there was substantial geographic variation in the rate of use of specific medical or surgical procedures. For example, the rate of tonsillectomies in one area of New England was six times higher than the lowest rate in the region.[13] While some of the variations uncovered in "small area analysis" might be attributable to differences in the incidence of illness in different populations, this explanation appeared to be insufficient to account for all the variation; some other factors had to be at work. One hypothesis was that physicians in different areas had different "practice styles." Each community had its own medical culture, its own characteristic way of diagnosing or treating particular diseases or conditions. Physicians adopted the practice style of their community in the absence of firm and objective information about which treatment approach was actually superior.

---

[7] Lindsey, Phoebe A. Medicaid Utilization Control Programs: Results of a 1987 Study. Health Care Financing Review, v. 10, no. 4, summer 1989. p. 79-92; and Gabel, Jon, et al. Employer-Sponsored Health Insurance in America. Health airs, v. 8, no. 2, summer 1989. p. 116-128.

[8] Feldstein, Paul, Thomas Wickizer, and John Wheeler. Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures. New England Journal of Medicine, v. 318, no. 20, May 19, 1988. p. 1310-14.

[9] For a review of the literature, see Ermann, Danny. Hospital Utilization Review: Past Experience, Future Directions. Journal of Health Politics, Policy and law, v. 13, no. 4, winter 1988. p. 683-704.

[10] For a discussion of this issue, see Institute of Medicine. Controlling Costs and Changing Patient Care? The Role of Utilization Management. Washington, 1989.

[11] Goldsmith, Jeff C. Competition's Impact: A Report from the Front. Health Fairs, v. 7, no. 3, summer 1988. p. 162-173.

[12] Grumet, Gerald W. Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon. New England Journal of Medicine, v. 321, no. 9, Aug. 31, 1989. p. 607-11.

[13] Wennberg, John, and Alan Gittelsohn. Variations in Medical Care Among Small Areas. *Scientific American*, v. 246, Apr. 1982. p. 120-134.

Other explanations have been offered for small area variations in medical practice; these will be discussed further below. However, the practice style hypothesis has won many supporters and has led to proposals for controlling medical care costs by (a) improving knowledge of the relative efficacy of different medical treatments and (b) disseminating this knowledge to practitioners in the expectation that they will modify their practice styles accordingly. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) establishes a new program within the Department of Health and Human Services for research on the effectiveness of medical treatments and the development of practice guidelines. Not all of the proponents of this initiative view it as a cost-containment measure. Some view it chiefly as a possible way of improving quality of care, and therefore worth pursuing whether or not any cost savings result. The following discussion, however, considers only the potential of medical practice research to reduce costs.

To have a significant impact, guidelines will need to address areas of practice on which there is real disagreement among physicians. There have been some efforts in the past to codify elements of medical practice on which there already existed a consensus. However, if most physicians already agree on the best treatments, promulgating that agreement in the form of guidelines may not have a measurable impact on medical practice. (This appears to have been the case, for example, with a 1984 consensus report on the treatment of high blood pressure.[14]) For this reason, the treatment research initiative will focus on conditions for which there is found to be a wide variation in current practice. Because the Nation is just beginning to devote significant resources to research on the outcomes of alternative medical treatments, it may take time for researchers to reach agreement in cases where practice variation is the result of real scientific uncertainty. The full potential savings from this strategy might therefore be realized only over the long term.

Assuming that future research can resolve disagreements over appropriate treatments, there would remain the task of inducing physicians to modify their practices voluntarily on the basis of the new findings. Some success in changing practices has been reported when physicians have been introduced to guidelines through structured face-to-face educational programs conducted by respected peers.[15] Some other efforts that relied only on printed materials to communicate practice recommendations have had disappointing results. Providers could be aware of and even approve the recommendations without making significant changes in practice. It is possible that some physicians may encounter barriers in implementing even guidelines with which they nominally agree. These may include concerns about malpractice liability, lack of the substitute skills or the special equipment needed to follow the guidelines, economic incentives, or pressure from patients.[16] These barriers might be overcome with more vigorous educational efforts. Still, countervailing economic and professional pressures may limit the willingness or ability of physicians to comply voluntarily with treatment guidelines.

One alternative is to use the results of outcomes research as the basis for mandatory, rather than voluntary, guidelines—that is, as a way of strengthening or broadening current utilization control programs. Proposals to do so have met strong opposition from the medical community, on the grounds that medicine cannot be reduced to a "cookbook" and that to compel physicians to comply with fixed practice rules would stifle innovation. In addition, there would remain the problem of achieving sufficient savings to offset the administrative costs of review systems.

---

[14] Hill, Martha N., David M. Levine, and Paul K. Whelton. Awareness, Use, and Impact of the 1984 Joint National Committee Consensus Report on High Blood Pressure. *American Journal of Public Health,* v. 78, no. 9, Sept. 1988. p. 1190-94.

[15] See Chassin, Mark R. Standards of Care in Medicine. Inquiry, v. 25, no. 4, winter 1988. p. 437-453.

[16] Lomas, Jonathan, et al. Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians. New England Journal of Medicine, v. 321, no. 19, Nov. 9, 1989. p. 1306-11; and Kosecoff, Jacqueline, et al. Effects of the National Institutes of Health Consensus Development Program on Physician Practice. *Journal of the American Medical Association,* v. 258, no. 19, Nov. 20, 1987. p. 2708-13.

Another option is to replace service.by-service utilization review with general comparisons of each physician's practice patterns to those of his or her peers. Physicians who, over time, consistently furnished or ordered more of certain services than others in the peer group would be targeted for closer scrutiny, to determine whether patterns of inappropriate utilization existed. Physicians found to be outliers might be the focus of special educational efforts in the hopes of inducing voluntary change. Continued noncompliance might trigger requirements that individual services receive prior authorization or could even lead to exclusion from participation in a given public or private insurance program.

How much could be saved if all inappropriate services were eliminated? Some studies have found very high rates of unnecessary care. For example, Chassin et al., in a thirteen-site study, found that 17 percent of all coronary angiographies were unnecessary; for other procedures, the rate of inappropriate use was as high as 32 percent. They also found, however, that the unnecessary care explained only a small fraction of variations in utilization across geographic areas. If none of the inappropriate angiographies had been performed, the area with the highest use of this procedure would still have had more than twice the number of angiographies as the lowest-use area. The authors suggest that other factors must play a part in this difference: disease incidence, differences in the point at which primary care physicians decide to refer patients to specialists, or cultural or social differences in the stage at which patients sought care.[17] Another multisite study has found that, while practice style may explain differences in utilization of certain specific procedures, it does not explain overall differences in per capita use of medical care in different areas. At the aggregate level, standard socioeconomic factors could explain much of the difference in use and intensity of services.[18]

These preliminary studies suggest that there could be underutilization of services in some areas, while there is overutilization of the same services in other areas. Treatment research could pinpoint, not only cases in which unnecessary services could be eliminated, but also cases in which patients have had insufficient access (whether physical or financial) to necessary care. It is for this reason that some proponents of outcomes research have emphasized its potential impact on quality, rather than its potential for cost savings. Precisely because there is uncertainty about the relative efficacy of many treatments, it may be too early to say whether optimal medical treatment would involve more or fewer services than are currently furnished.

SUPPLY CONTROLS

If utilization controls or practice guidelines succeed in limiting unnecessary care, the full potential savings from any reduction in the number of services delivered may be realized only if there is a proportionate reduction in the resources used to provide those services. For example, changes in medical practice in the late 1970s and early 1980s led to a decline in inpatient hospital admissions without a corresponding reduction in hospital capacity. The result in many areas has been underutilized facilities spreading their fixed costs across a declining number of patients; while there are fewer patients, the cost for each patient rises because the unused capacity must still be paid for.

In addition, the existence of excess capacity may generate continuing pressures to find some new way of using that capacity and restoring utilization to its previous levels.[19] The view that the use of medical services could rise to fill any underused resources led to what was perhaps the dominant approach to cost containment in the 1970s: health planning, the regulation of facility construction and other capital expenditures.

In 1964, New York became the first State to establish a certificate-of-need (CON) program, under which proposals to build a new facility or expand an existing one had to be approved by a government agency. Other States followed, and a 1972 amendment to the Social Security Act provided that facilities in those States proceeding with construction without obtaining a CON could be denied Medicare and Medicaid reimbursement for their capital expenditures. Finally, the Health Planning and Resources Development Act in 1974 required all States to establish similar programs. This requirement was repealed in 1986, along with all Federal support for State health planning programs. States may continue to operate programs on their own; 39 States and the District of Columbia still do so. However, Medicare reimbursement is no longer contingent on State approval of capital expenditures, and a number of States have now limited their reviews to nursing home construction.[20]

---

[17] Chassin, Mark R., et al. Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? Journal of the American Medical Association, v. 258, no. 18, Nov. 13, 1987. p. 2533-2537.

[18] Folland, Sherman, and Milan Stano. Sources of Small Area Variations in the Use of Medical Care. Journal of Health Economics, v. 8, no. 1, Mar. 1989. p. 85-107.

[19] The view that hospital admissions rise in proportion to hospital bed capacity was originally advanced by Hilton Roemer, in Bed Supply and Hospital Utilization: A Natural Experiment. *Hospitals*, v. 35, no. 21, Nov. 1, 1961. p. 36-42; Some more recent studies have concluded that the relation between supply and utilization may not be as straightforward as "Roemer's law" would suggest. Brewer, W. Ross, and Mary Anne Freedman. Causes and Implications of Variation in Hospital Utilization. *Journal of Public Health Policy*, v. 3, no. 4, Dec. 1982. p. 115-454.

Several factors contributed to the reversal of policy on health planning. In part, it fell victim to the general preference for market as opposed to regulatory solutions during the early 1980s. From a Federal perspective, the adoption in 1983 of Medicare's prospective payment system (PPS) for inpatient hospital services was expected to offer a different way of limiting health care resources; this approach is discussed further in the next section.[21] Underlying this shift, however, were claims that health planning had been tried and had failed, largely because of conflicting political pressures. In many areas, the oversupply of facilities was such that savings would have required, not just limits on new construction, but closure or consolidation of existing facilities. Few States were able to overcome the political resistance to such closures. Attempts to limit duplication of services or the spread of new technologies often faced similar barriers; attempts to plan for the rational distribution of resources on a regional basis had to confront providers' fears of losing to competitors and individual communities' desires for the most up-to-date facilities.[22]

CON programs did have some successes, particularly in constraining the growth in nursing home beds. Because State Medicaid programs are the major source of payment for nursing home care, States had a strong motive to overcome the political barriers to supply constraint. In at least some States, the CON process was explicitly seen as a Medicaid cost-containment measure; the determination of the number of nursing home beds needed was related to the maximum number of patients the State was prepared to cover.[23] Even in this case, however, any savings were achieved by holding growth in bed supply below the rate of growth in the aged population. States generally did not close down existing capacity.

Recent concern about the rate of medical care cost increases has led to some calls for a revival of health planning, and it is conceivable that these concerns might eventually be sufficient to overcome the political barriers faced by health planners in the past. However, not all of the problems with health planning are political ones. Effective planning may require a fuller understanding of the workings of the health care system than is currently available. That system is a dynamic one, and decisions that seemed sensible in the late 1970s have sometimes had unpredictable effects. For example, most planning programs focussed on institutional services in hospitals and nursing homes, because these were the major sources of expenditure, and did little to control the capital expenditures of community-based physicians or clinics. The resulting growth in the availability of high-technology facilities outside hospitals is one of the reasons that recent reductions in inpatient utilization have been offset by increased outpatient costs. (Some States are now applying uniform rules across settings.)

Moreover, a community's needs may change unpredictably. New York was more successful than most States in controlling inpatient bed supply; it was one of the few States in which hospital closures occurred on a planned basis. While the number of community hospital beds nationally dropped 1.1 percent between 1977 and 1987, the number in New York dropped 9.9 percent.[24] New demands on these

---

[20] American Hospital Association. State Issues Forum. State Health Planning Report. Chicago, July 1989.

[21] The inclusion of capital expenditures in PPS payments has been repeatedly postponed. Hospitals are instead paid for Medicare capital expenses on a reasonable cost basis, subject to a fixed percentage discount (15 percent beginning Jan. 1, 1990).

[22] For an overview of the barriers to health planning, see Brown, Lawrence D. Common Sense Meets Implementation: Certificate-of-Need Regulation in the States. *Journal of Health Politics, Policy and Law,* v. 8, no. 3, fall 1983. p. 480-494. (Hereafter cited as Common Sense Meets Implementation.)

[23] Feder, Judith, and William Scanlon. Regulating the Bed Supply in Nursing Homes. *Milbank Quarterly,* v. 58, no. 1, 1980. p. 54-88.

[24] American Hospital Association. Hospital Statistics, 1978 and 1988 editions. The fullest potential savings from health planning would require a more controversial step: limiting the supply of health resources to the point at which patients may have to wait for some period to obtain needed but non-emergency services. The result is "queuing," the delays in surgery or

Continued

facilities in the 1980s, such as the appearance of AIDS (acquired immune deficiency syndrome) and the rise in drug-related problems, have led to serious overcrowding in some New York hospitals. The reported crisis in New York illustrates one of the potential constraints on the planning process. On the one hand, it may be necessary to maintain enough excess capacity to meet unforeseen needs or random fluctuations in demand. On the other hand, this excess capacity is costly to maintain and may itself generate demand. If the supply of a given kind of service is sufficient that no one ever has to stand in line for it, then the savings from health planning may be limited.

Whatever the extent to which resources have been limited elsewhere, rationing of supply in the United States might raise concerns that are not as significant in countries where the entire population participates in a single insurance program. In those countries, everyone is in the same queue, and one's place in line is chiefly determined by the urgency or duration of one's need. (There are exceptions: one can step out of line in the United Kingdom by finding a private provider, and there are anecdotal accounts that some Canadians with sufficient resources may seek care in the United States.) When queueing has occurred in the United States, however, places in line may have been determined by financial resources.

The facilities in New York reporting the greatest overcrowding have been those serving the poor and the uninsured. Similar effects may have resulted from health planning's major success, the control of nursing home bed supply. Because Medicaid payment is generally less than that available from private patients, nursing homes in areas with limited bed supply and high occupancy rates have an incentive to accept a private-pay patient when a vacancy occurs, while Medicaid beneficiaries may be unable to find a place. In 28 States, Medicaid administrators report that beneficiaries awaiting hospital discharge had difficulty finding a nursing home bed.[25] While supply constraints are not the only factors limiting access to care for low-income Americans, they may exacerbate existing problems. The acceptability of health planning as a cost control strategy may, then, depend in part on the extent to which supply limitations are accompanied by efforts to make distribution of limited resources more equitable.

One other issue should be raised in the context of a discussion of health resources: the debate over the possible oversupply of physicians and the potential consequences of physician supply on health care costs. In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) reported that the United States would have a surplus of 150,000 physicians by the year 2000.[26] The extent of the potential surplus has since been the subject of continuing debate. There are questions about the extent to which technology and the aging of the population could increase demand, or the adoption of utilization controls or managed care could decrease it. The number of medical school admissions could decline, or physicians might spend more of their time on administrative activities and less on patient care.[27]

Even less clear than the extent of the future surplus is its possible effect on medical costs. Observations that per capita use of physician services increases in geographic areas with a high ratio of physicians to population have led to the hypothesis of "physician-induced demand." Just as excess hospital bed capacity may generate more hospital stays, this theory holds that a surplus of physicians all attempting to maintain their incomes would lead —in the absence of any controls—to excess delivery of services. Repeated efforts to demonstrate this have been inconclusive.[28]

---

high-cost diagnostic procedures that are alleged to occur to some extent in Canada and to a greater extent in the United Kingdom. The degree to which queueing actually occurs in either country's health system has often been debated by those who favor or oppose adoption of a similar system here. Some people say that essential care may be unavailable, while others argue that resource limits merely oblige providers to set priorities and avoid unnecessary services.

[25] For a fuller discussion of this problem, see U.S. Library of Congress. Congressional Research Service. *Medicaid Source Book: Background Data and Alysis*. Report prepared for the House Committee on Energy and Commerce. Washington, Nov. 1988. (Committee print 100-AA) p. 467-83. (Hereafter cited as Congressional Research Service, *Medicaid Source Book.)*

[26] Graduate Medical Education National Advisory Committee. Report to the Secretary, U.S. Department of Health and Human Services. Washington, 1980.

[27] For contrasting views on these issues, see Schwartz, William B., Frank A. Sloan, and Daniel N. Mendelson. Why There Will Be Little or No Physician Surplus between Now and the Year 2000. New England Journal of Medicine, v. 318, no. 14, Apr. 7, 1988. p. 892-897; Schloss, Ernest P. Beyond GMENAC—Another Physician Shortage from 2010 to 2030? New England Journal of Medicine, v. 318, no. 14, Apr. 7, 1988. p. 920-922.

[28] See Rossiter, Louis F., and Gail R. Wilensky. A Reexamination of the Use of Physician Services: The Role of Physician-Initiated Demand. Inquiry, v. 20, no. 2, summer 1963. p. 162-72; Langwell, Itathryn M., and Lyle M. Nelson. Physician Payment Systems: A Review of History, Alternatives and Evidence. Medical Care Review, v. 43, no. 1, spring 1986. p. 5-58.

It is not clear that physicians actually modify their medical practice in order to maintain a "target income." Still, if the projected surplus does in fact appear, there might be greater pressures on physicians to increase the number of services they furnish to each patient. Some people believe that it may eventually be necessary to consider reducing the supply of physicians (or curtailing their working hours).

This has actually been attempted in one Canadian province, British Columbia. A physician who wants to participate in the health program that covers all citizens of the province must have a billing account, and since 1985 the number of accounts has been limited (limits vary by specialty and geographic area). A physician who fails to obtain a billing number cannot earn a living as a physician. Critics of the system contend, however, that British Columbia is merely exporting its physician surplus to other provinces or to the United States.[29] Given the political problems health planners in the United States have experienced in trying to close hospitals, it seems unlikely that British Columbia's efforts could be reproduced here, with government regulators telling new medical school graduates to find some other profession. However, there are proposals to achieve the same goal through private means. Some of the more ambitious "managed care" agendas discussed in the final section of this report contemplate enrollment of the entire population in health maintenance organizations (HMOs) or other structured delivery systems that would match their resources to the needs of the enrolled population; this approach would potentially reduce employment opportunities for physicians.[30]

REIMBURSEMENT REFORM

Proposals for reimbursement reform begin with the premise that traditional payment systems, under which providers receive their full costs or charges for whatever services they choose to furnish, encourage inefficiency and the delivery of unnecessary care.

The simplest type of reform is for payers to set fixed prices for defined units of service, such as a day of inpatient care or a physician office visit. However, this approach may not reduce costs if providers are able to modify the volume or nature of the services they provide to make up for the lost revenue on individual services. For this reason, the focus of reimbursement reform proposals is on developing pricing mechanisms that give providers incentives to control both volume and unit cost.

This is generally accomplished by redefining the commodity the insurer is purchasing. Instead of paying for individual units of service, the insurer makes one payment for an episode of care (as in Medicare's prospective payment system, PPS), for overall treatment of a patient during a given time period (capitation), or for treatment of an entire population (as in Canada's global budgeting system for hospitals). These approaches may be seen as aligned on an ascending scale depending on the degree of aggregation of the unit being purchased, with per-case payment at the low end and payment for an entire patient population at the other. In all cases, however, the aim is to define in advance the total amount of resources the provider may consume in furnishing treatment to a patient or group of patients.

Per-case payment and capitation give the provider an incentive to perform more efficiently in treating individual patients, either reducing the cost of producing each unit of service or reducing the number of units furnished to each patient. These approaches may therefore be seen as alternatives to external utilization controls. Global budgeting defines the total resources available for treating all patients, and may be seen as an alternative to health planning.[31] Reimbursement controls have the same goals as direct regulation of medical practice and supply, but shift the responsibility for decision-making from the third-party payer or the government to the actual providers of care. In order to live within the established rates or budgets, the providers must be self-regulating; they must make the same sorts of treatment and resource allocation decisions that would otherwise have been imposed externally.

---

[29] Barer, Morris L. Regulating Physician Supply: The Evolution of British Columbia's Bill 41. Journal of Health Politics, Policy, and w. v. 13, no. 1, spring 1988. p. 1-25.

[30] For example, Alain Enthoven has characterized the "buy right" scheme advanced by Walter McClure as requiring that "good-quality, efficient doctors prosper while others are induced to retire." Enthoven, Alain C. Managed Competition in Health Care and the Unfinished Agenda. Health Care Financing Review, 1986 Annual Supplement. p. 105-119.

[31] In practice, the Canadian system uses both global budgeting and health planning. However, some of the rate regulation systems in the United States have explicitly superseded the health planning system. A facility that has obtained a certificate of need for expansion may proceed only if the rate commission approves the necessary increase in capital costs. For a discussion of the interplay of planning and rate regulation, see Brown, Common Sense Meets Implementation.

As the Medicare program has demonstrated, it is possible for a single payer with sufficient market power to adopt such reimbursement changes on its own.[32] The effects of this unilateral approach in a pluralistic system are uncertain. While some providers may be driven to improve their efficiency, others may instead respond to shortfalls in reimbursement from one payer by raising charges to other groups, those without the market power to dictate prices. The possibility of "cost-shifting" may mean that savings for one purchaser are not translated into real reductions in total system expenditures.

In a sufficiently competitive market, the providers' ability to engage in this "cost-shifting" may be limited. A hospital may face, not only payment limits under Medicare and Medicaid, but pressure from private insurers or employer groups to grant price discounts in order to be assured of an adequate market share. Characteristics other than efficiency may determine a provider's success in the face of these competing demands. For example, a suburban non-teaching hospital with few uninsured patients may be at a relative advantage as compared to a center city teaching facility with a heavy uncompensated care load. Individual purchasers who reduce their costs by favoring the suburban hospital may leave the society to find some other means of subsidizing essential facilities that are handicapped in price competition.

A system in which multiple payers negotiate individually with providers may, then, lead either to cost-shifting or to a situation in which price concerns override other societal goals, such as medical education and charity care. For this reason, some people argue that real efficiency can be achieved only if all payers are paying under the same rules.

Uniform ratesetting is common in other industrialized nations, both those with single-payer health insurance systems (as in Canada) and those where many different entities provide insurance (as in West Germany). The experience in the United States is limited to experiments in a few States beginning in the 1970s. Federal waivers of Medicare and Medicaid rules made it possible for those two payers to participate in the programs on a demonstration basis, while State laws compelled participation by private insurers and individual payers, resulting in an "all-payer" system. Medicaid law now permits any State to include Medicaid in such a system, and Medicare may be included if the State can show that its system controls costs as effectively as PPS. However, full "all-payer" systems continue only in Maryland and in part of New York State. Several other States operate "partial-payer" systems that include all payers except Medicare.[33] These systems have generally used the price aggregation approaches described above. That is, they either establish a rate for total treatment of a case (as under PPS) or they establish a total budget for a hospital during a year, setting prices for the hospital in such a way as to achieve a target revenue amount.

It has been shown that, in 6 States with ratesetting systems, annual increases in cost per admission were consistently 3 to 4 percentage points below the national average from 1976 to 1984. During the same period, however, other States saw a drop in admissions per capita, while admissions in the ratesetting States were stable. As a result, the difference in growth in per capita rates of spending was not so striking: per capita costs rose at an annual rate of 11.5 percent a year in the ratesetting States and 13 percent a year in other States.[34] In addition, the ratesetting States had much higher costs at the outset than most other States. Some observers have questioned whether ratesetting could have achieved comparable savings in areas where costs were lower to begin with.[35]

Evidence from other countries with universal ratesetting systems suggests that greater savings may be possible. In Canada, where the provinces establish global budgets for each hospital, hospital expenditures per capita were one-third lower than in the United States in 1985. (Similar systems in other industrial nations have been less successful.)[36] As admission rates are not markedly lower, there is considerable uncertainty about the sources of the difference. Some of the saving may be in administrative costs, simply because the hospitals do not need to meet the paperwork requirements of multiple payers. The rest of the difference is often attributed to differences in the intensity of the services furnished to each patient. Whether these differences reflect "underservice" in Canada or "overservice" in the United States is the subject of continuing debate.[37]

---

[32] As the Medicaid experience has shown, adoption of payment restraints by a payer with too small a market share may reduce access for the payer's enrollees. For example, low reimbursement rates are the major reason physicians decline to participate in the Medicaid program. See Congressional Research Service, Medicaid Source Book, p. 448–454.'

[33] Maine's system takes hospitals' Medicare revenues into account when determining what the hospitals may charge other payers, thus achieving overall budgetary control without direct Medicare participation. This approach has recently survived a legal challenge by hospitals.

[34] Schramm, Carl J., Steven C. Renn, and Brian Biles. New Perspectives on State Rate-Setting. *Health Affairs,* v. 5, no. 3, fall 1986. p. 22–33.

[35] Eby, Charles L., and Donald R. Cohodes. What Do We know About Rate-Setting? *Journal of Health Politics, Policy, and Law,* v. 10, no. 2, summer 1985. p. 299–327.

In a sense, the statistical evidence may be beside the point. An all-payer system could in theory fix its prices at any level, with the potential consequence of reduced access or quality if the prices are set too low. The available data may thus be taken as indicating, not the savings that could hypothetically be achieved, but the savings that were politically feasible in specific States during a specific period. Continuing pressure by consumers and providers for the adoption of new medical technologies may limit the ability of ratesetting systems to restrain expenditure growth over the long term. Even in Canada, overall medical expenditures outpaced inflation by 2.9 percent a year in the period 1980-87, almost the same as the 3.0 percent annual rate observed in the United States in the same years.[38] The ultimate efficacy of reimbursement controls may depend, in the same way that the success of health planning depends, on the political will to constrain health care consumption.

That political will might in turn depend on perceptions of the impact of reimbursement controls on the quality of care. The effect of Medicare's prospective payment system, for example, has been argued continuously since its implementation in 1983. One of the immediate responses of hospitals to the incentives of the new system was to shorten the average length of stay in the hospital for each Medicare patient (although average length of stay had already been dropping for several years). Opponents of the new system have contended that patients were being discharged "quicker and sicker," transferred to their own homes or to nursing homes at a stage in their recovery when they still required hospital-level care. Because of a lack of satisfactory measures of medical care outcomes for large populations, evidence on this issue remains largely anecdotal. Still, the possibility that there has been a deterioration in quality of care for at least some Medicare patients since the implementation of PPS cannot be ruled out. The hospitals themselves argue that current payment levels are insufficient to maintain adequate quality. At the same time, the Administration and the Prospective Payment Assessment Commission (the independent commission that reviews PPS) have argued that hospitals are still not operating at peak efficiency and that further pa3ym9ent restraint is needed to provide continued incentives for cost reduction.[39]

This debate illustrates one potential dilemma in the strategy of achieving savings by relying on the political process to limit the financial resources available to providers. On the one hand, legislators driven by budgetary concerns may continue to ratchet down spending limits until they have clear evidence that quality has been seriously affected. On the other hand, provider or constituent pressure may lead them to relax those limits before the providers have done everything possible to improve their efficiency.. Because no one knows the ideal amount to spend on medical care, some people say that this process can never achieve equilibrium and that cost control efforts should instead depend on the process through which other sectors of the economy achieve "correct" spending levels: the free market. Proposals for encouraging competition in health care represent the last of the strategies to be reviewed in this report.

COMPETITION

The idea of reducing health care costs by promoting competition in the health care marketplace was last advanced in the 1970s. Some analysts, arguing that such initiatives as rate regulation, health planning, and utilization review had been compromised by political interference, contended that the free market was better equipped to control costs than Government was. By the early 1980s, this view had wide currency and had become the official policy of the Reagan Administration. Since then, there has been a continuing debate between advocates of competition and those who favored further regulatory interventions by Government. The debate has been complicated by a lack of agreement over what "competition" consists of. What is the health care market? Who are the purchasers, and what are they buying?

---

[36] Organization for Economic Co-Operation and Development. Financing and Delivering Health Care: *A Comparative Analysis of OECD Countries*. Paris, 1987. (OECD Social Policy Studies No. 4.) p. 63.

[37] For a variety of views on this subject, see the series of articles on Canada's hospital system in *Health Affairs*, v. 7, no. 5, winter 1988.

[38] Schieber and Poullier, International Health Care Expenditure Trends: 1987.

[39] U.S. Prospective Payment Assessment Commission. Report and Recommendations to the Secretary, U.S. Department of Health and Human Services. Washington, U.S. Govt. Print. Off., Mar. 1989; For a recent review of hospital cost responses to PPS, see Sheingold, Steven H. The First Three Years of PPS: Impact on Medicare Costs. Health Affairs, v. 8, no. 3, fall 1989. p. 191-204.

In a simple market, hospitals and physicians would compete directly for the individual consumer's dollar. The consumer would pick the best values just as he or she does when buying any other commodity. As was suggested in the discussion of cost-sharing, it is not clear that consumers are capable of making such evaluations; moreover, many purchasing decisions are made by physicians on their patients' behalf rather than directly by consumers. Finally, because few people can afford the costs of care for a major illness, most of the consumer's dollar is spent on health insurance, not on medical care itself. As was suggested earlier, this is true even when the insurance plan imposes cost-sharing requirements on enrollees, because most health care costs are incurred by a relatively small number of high-cost cases. For this reason, most proponents of competition are really talking about price competition among insurers, and only indirectly among providers.

If the insurer is—as traditional health insurance plans were—a passive payer for services obtained by policyholders, there is little room for serious price competition. The only element of cost that the insurer can control is its own administrative cost. Competition, if any, may turn on such non-price factors as reputation or the insurer's ability to screen out high-risk applicants.[40]

Competition among insurers can result in real cost savings only if the insurers have some influence on the costs of health care itself. In this model, insurers compete to offer lower prices by acting as prudent purchasers, proxies for the rational consumer. The insurers are selling a new product, no longer simply insurance, but "insured health care." To some extent, this new insurance market has already arrived. As was suggested earlier, most insurance plans, both public and private, have adopted some utilization control measures. Very few insurers are still passive bill-payers.

Once all insurers have adopted these basic cost control measures, further competition would presumably require more aggressive interventions by insurers in the health care system. Proponents of competition contemplate a marketplace in which insurers develop structured delivery systems, with the highest profits going to those whose networks are most efficient. The prototype for these systems is the HMO. More recently, some insurers have been experimenting with hybrid programs, such as "point-of-service plans," that are less structured and provide somewhat greater flexibility to enrollees.

Health Maintenance Organizations

A health maintenance organization (HMO) is a form of health insurer; like any other insurer, it accepts financial responsibility for a defined set of health care benefits in return for a fixed monthly per capita premium. Unlike other insurers, HMOs directly provide or arrange for health care services, through affiliated physicians, hospitals, and other providers. The enrollees covered by the HMO agree to obtain all services, except emergency and out-of-area care, from or with the authorization of the HMO or its affiliated providers. The HMO has no liability to pay for unauthorized non-urgent care obtained outside the organization. Ordinarily, the enrollee's point of entry into the system is through a single primary care provider, who functions as a "gatekeeper," determining when a patient may see a specialist or be admitted to the hospital. The HMO exerts further administrative controls on use of services through authorization mechanisms and/or treatment protocols. HMOs also use a variety of other cost-saving techniques, such as negotiated discounts with providers and payment mechanisms that place individual providers at risk for the costs of the services they furnish or order.

The particular cost-saving techniques adopted by HMOs and other "managed care" plans are not fundamentally different from the regulatory approaches described in the preceding sections. An HMO imposes external utilization review on its participating providers and may develop practice guidelines or protocols. Staff or group practice model HMOs (those that employ physicians on a full-time basis) impose supply constraints, limiting available resources to those needed by their membership. Individual practice associations (IPAs, whose physicians practice in their own offices and see a mix of HMO and non-HMO patients) use payment methods that create financial incentives to control utilization, such as capitation or expenditure targets.

---

[40] Alain Enthoven has summarized the alternatives to price competition: "[S]election of preferred risks, market segmentation, product differentiation that raises the costs of comparing products, discontinuity in coverage, refusal to insure certain individuals or exclusion of coverage for treatment of preexisting medical conditions, biased information regarding coverage and quality, and erection of entry barriers [that is, to new competitors]." Enthoven, Alain C. Managed Competition of Alternative Delivery Systems. *Journal of Health Politics, Policy and Law,* v. 13, no: 2, p. 305-321.

One additional cost-saving approach that was once unique to HMOs is "gatekeeping." Under a gatekeeping approach, a patient receives all non-emergency care from, or with the authorization of, a single primary care provider. The provider thus functions as a "gatekeeper," preventing the enrollee from independently accessing specialists or other services and presumably managing the overall care of the patient. The extent to which gatekeeping produces savings over and above those provided by the other cost-saving techniques adopted by HMOs is uncertain. The results of one experiment, the SAFECO health plan operated by United HealthCare in the early 1980s, suggest that gatekeeping alone has little effect on overall cost. bile primary care providers reduced the number of referrals to specialists, they were unable to control the behavior of the specialists once a referral had occurred. There was no meaningful reduction in hospital admissions, 70 percent of which were controlled by the specialists.[41] Greater success has been reported by some State Medicaid programs, which have established "primary care case management" programs for segments of their covered populations. Gatekeeping reduced such inappropriate behaviors as the use of emergency rooms for primary care. However, the utilization patterns addressed by these programs may be characteristic of Medicaid beneficiaries in the inner city and not of other groups; it is not clear that equivalent savings could be achieved with a general population. There is some evidence that most patients' care is already "managed" by their primary care physicians, at least to the extent that it is managed under formal gatekeeping arrangements.[42]

Aside from the uncertain effects of gatekeeping, managed care depends on the same kinds of interventions in medical care practice, supply, and financing that might otherwise be attempted on a regulatory basis. The difference is that, instead of relying on the political process to make decisions about the allocation of health care resources, managed care privatizes these decisions. The choice among alternative cost control methods—and the stringency with which these methods will be applied—will be made by the free market. The fundamental contention of proponents of the competitive approach is that the market can impose discipline on the health care system that cannot be imposed through external regulation.

This contention rests on two key assumptions: first, that buyers will, all other things being equal, select the most cost-effective plan; second, that managed care offers greater cost-saving potential than the various regulatory controls described earlier.

One critical factor has made it difficult to generalize about the efficacy of HMOs as a cost-saving approach: the problem of "biased selection" in systems that allow a choice between a conventional health insurance plan and an HMO. Numerous studies of such "dual choice" employer group plans have shown that the members of the group choosing the HMO option used fewer health services before their enrollment than persons who chose an conventional plan. Similar patterns have been observed in Medicare HMO enrollment.[43] This does not necessarily mean that HMO enrollees were healthier. Studies using self-reported condition and similar limited measures of health status have found no difference between HMO and indemnity enrollees. It may be, then, that HMO enrollees are simply less prone to seek health services, regardless of their condition.[44]

---

[41] Moore, Stephen, Diane Martin, and William Richardson. Does the Primary-Care Gatekeeper Control the Costs of Health Care? Lessons from the SAFECO Experience. *New England Journal of Medicine,* v. 309, no. 22, Dec. 1, 1983. p. 1400–1404; For the extent to which specialty referrals may determine overall costs, see Glenn, John K., Frank H. Lawler, and Mark S. Hoerl. Physician Referrals in a Competitive Environment: An Estimate of the Economic Impact of a Referral. *Journal of the American Medical Association,* v. 258, no. 14, Oct. 9, 1967. p. 1920–23.

[42] Dietrich, A.J., et al. Do Primary Physicians Actually Manage Their Patients' Fee-for-Service Care? *Journal of the American Medical Association, v. 259, no. 21, June 3, 1988. p. 3145–49.*

[43] For a review of the evidence, see U.S. General Accounting Office. Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings. Report to the Chairman, Subcommittee on Health, House Committee on Ways and Means. Washington, Nov. 1989. [GAO/HRD–90–38]

[44] Hellinger, Fred J. Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence. Health Care Financing Review, v. 9, no. 2, winter 1987. p. 55–63.

In groups that have no HMO option but do offer a choice between high- and low-option plans the common selection pattern is for the higher users of services to choose the more comprehensive plan.[45] In most group health programs offering a choice between HMOs and conventional plans, the HMO options offer more comprehensive coverage, with less enrollee cost-sharing, than even a high-option conventional plan. That higher users of services still prefer the conventional plan suggests that non-financial aspects of HMOs affect the decision, such as limited choice of providers, bureaucratic constraints on treatment, or waiting time for non-urgent care. There is stronger evidence of biased selection for staff and group model HMOs, the most restrictive, than for IPAs, which are less likely to disrupt enrollees' traditional ways of obtaining medical care.

Possible solutions to the problem of selection bias will be discussed further below. One immediate consequence, however, is that the differences between the populations in HMOs and conventional plans have made it difficult to determine whether HMOs are actually more efficient than other insurers. Only one major study has corrected adequately for this problem. In a second component of the RAND Health Insurance Experiment (HIE) cited earlier, enrollees were randomly assigned to the Group Health Cooperative of Puget Sound and an equally comprehensive conventional plan; neither plan required cost-sharing. This arrangement allowed comparisons of efficiency with identical benefits and populations with comparable health needs. The results strongly confirmed the cost-saving potential of the HMO. The HMO enrollees had 40 percent fewer hospital admissions; their use of ambulatory services was about the same as that of the conventional enrollees. Overall, costs for the HMO group were estimated to be 28 percent lower than for the control group.[46] There were no perceived effects on quality; measures of health outcomes were generally the same for both groups.[47]

While the HIE findings are persuasive, two factors may limit the general applicability of the results. First, the study was conducted in the late 1970s; the comparison plan was the passive bill-payer prevalent in the insurance industry in that period, with no utilization control mechanisms. The more recent adoption by conventional plans of some of the cost-control measures once associated only with HMOs may mean that the difference in efficiency between the two types of plan has narrowed.

Second, the HMO used in the Health Insurance Experiment was a highly structured group-practice plan with many years of operating experience. Much of the growth in the industry in recent years has involved a different type of HMO, the individual practice association (IPA), which contracts with independent physicians who see a mix of HMO enrollees and other kinds of patients. There is evidence that these more loosely structured HMOs have not achieved savings comparable to those observed in the HIE.[48] Physicians may not modify their styles of practice in treating HMO enrollees if those enrollees constitute only a small share of their practice. In addition, some people believe that HMOs cannot impose cost-consciousness on practitioners who have not "signed on" to the concept of more efficient and less resource-intensive practice. Because so little is still known about the relative efficacy of different medical practices, external utilization controls may not be able to override individual physicians' judgment in many cases. The greater success of the "closed panel" plan, whose physicians treat HMO enrollees exclusively, has been attributed by some observers to the possibility that these plans attract physicians who are temperamentally more prone to conservative medical practice.

Because closed panel plans maintain their own medical facilities, they require greater start-up funding than IPAs. Federal funds were available to develop such plans in the 1970s, but new plans must now rely on private investment. Investors have favored IPAs, not only because they require less capital, but also because the wider selection of physicians makes them more attractive to consumers. This attraction may, however, be purchased at the price of reduced efficiency.

---

[45] Broyles, Robert W., and Michael D. Rosko. The Demand for Health Insurance and Health Care: A Review of the Empirical Literature. Medical Care Review, v. 45, no. 2, fall 1986. p. 291–338.

[46] Manning, Willard 6., et al. A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services. *New England Journal of Medicine*, v. 310, no. 23, June 7, 1984. p. 1505–10.

[47] Ware, John E., Jr., et al. Comparison of Health Outcomes at a Health Maintenance Organization With Those of Fee-for-Service Care. *Lancet*, May 3, 1986. p. 1017–22. One group, low-income HMO enrollees with existing health problems, had poorer outcomes, possibly because of difficulty dealing with the HMO's internal bureaucracy.

[48] For the most recent findings, see Hillman, Alan, Mark Pauly, and Joseph Kerstein. How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations? *New England Journal of Medicine*, v. 321, no. 2, July 13, 1989. p. 86–92.

Finally, while some types of HMOs or similar organizations may be able to reduce costs relative to conventional plans, it is not clear that they have so far reduced *growth* in health care costs. Data from 1961 through 1981 suggest that HMOs may instead achieve a one-time saving, after which costs rise at the same rate as those for other insurance programs. One explanation that has been offered is that providers in HMOs are as likely as other providers to use new medical technologies.[49] More recent data suggest that HMO premium increases have continued to resemble those of conventional insurance plans. The average HMO premium increase during 1988 was 17.2 percent, very close to the 19 percent increase for all employer coverage cited at the beginning of this report.[50]

That HMO cost increases have paralleled those of other insurers does not necessarily mean that HMOs have reached the limit of their cost-saving potential. Because competition among health insurers was relatively limited until recent years, many HMOs may not have faced the market pressures that could induce them to achieve greater savings. The next section reviews proposals to strengthen competition.

Competition and Consumer Choice

The competitive strategy depends on the willingness of consumers to choose the most cost-effective plans. As was suggested earlier, the consumers most likely to incur high costs may be least likely to choose the most efficient option. The problem of biased selection might persist even if conventional insurance plans were to disappear and consumers were able to choose only among managed care options. (Some industry analysts believe this will occur in the near future, chiefly because employers will refuse to offer conventional plans.) It is possible that the most costly patients, given a choice among competing managed care plans, would choose the plan that was least restrictive and potentially least able to achieve cost savings. The most efficient plans might continue to enroll the healthiest patients, for whom only limited savings are possible.

Some people believe that biased selection is largely attributable to the fact that consumers are economically sheltered from the cost of their choice of plan, because most of the premium is paid by the employer. Various schemes have been advanced to make the employee more cost-conscious. For example, the employer's contribution might be tied to the cost of the least expensive offering, with the employee bearing the full cost of the difference between that plan and other more expensive options.

However, selection bias can occur even when the choice of the more expensive plan has real financial consequences for the enrollee. Under the Federal Employees Health Benefits Program (FEHBP), the monthly employee share of premium costs in 1990 ranges from $20.54 in the least expensive high-option HMO to $234.07 in the most costly high-option conventional plan, a difference of $213.53 per month.[51] Under one possible fixed contribution scheme, the Federal share of both plans would be set equal to the full cost of the HMO ($82.16); the employee share would then be zero for the HMO and $265.29 for the conventional plan. If some Federal employees or annuitants are already willing to pay 11 times as much as others in order to obtain the conventional plan, it is not clear that even this change would cause all of them to shift to the HMO. For at least some subset of enrollees, the preference for unrestricted coverage is apparently sufficient to override even strong financial incentives.

One possible solution to the problem of enrollee self-selection is to abandon multiple choices and oblige all members of a covered group to enter a single plan, one selected by the employer or other buyer from among competing plans. Assuming that employers disregarded their own personal plan preferences and chose the least costly option, this approach would theoretically lead to competition among plans on the basis of efficiency. However, both employers and HMOs have been hesitant to enter into arrangements under which enrollees are unwillingly locked into a highly restrictive plan. For this reason, there have evolved arrangements even less restrictive than IPAs, known as open-ended or point-of-service plans.

---

[49] Newhouse, Joseph P., et al. Are Fee-for-Service Costs Increasing Faster Than HMO Costs? *Medical Care,* v. 23, no. 8, Aug. 1985. p. 960–66.

[50] InterStudy. *The Bottom Line: HMO Premiums and Profitability, 1988–1989.* Excelsior, Minn., 1989. Staff and group model HMOs generally had lower increases, possibly confirming their greater efficiency. However, these HMOs also tend to be older than IPAs; age of the HMO was also a determinant of the rate of increase.

[51] The conventional plan is national, while HMOs are offered only in specific locations. The comparison presented here applies only in one area (Tampa, Florida) and represents the extreme of variation in the FEHBP system. are expected to result from encouraging enrollees to use the participating providers.

The predecessor of these plans is the preferred provider organization (PPO). PPOs negotiate discounted rates with certain providers. Enrollees are given a financial incentive, in the form of reduced deductible or coinsurance requirements, to obtain care from providers participating in the PPO network. However, payment will be made under the plan for services furnished by any provider. PPOs thus differ from HMOs, which deny payment altogether for unauthorized non-emergent care provided by providers outside the HMO network. While some PPOs have adopted managed care techniques, such as the use of gatekeepers, most of the savings from a PPO

The newer, open-ended plans are hybrids, combining some features of HMOs and PPOs. Typically, the plan operates a structured health care system comparable to that of an IPA-model HMO. Enrollees are expected to access the system through a primary care gatekeeper and obtain services from other network providers upon referral by the gatekeeper. Like an HMO, the plan also imposes external utilization controls and negotiates price discounts with providers. As in a PPO, enrollees are free to use non-network providers for covered services, but must pay higher cost-sharing amounts if they choose to do so. Enrollees are also subject to higher cost-sharing if they use specialists within the network without the authorization of the gatekeeper.

Open-ended plans have been adopted by some employers as the single plan available to their workers, replacing systems in which the workers had a choice between conventional and HMO options. Their attraction has been that they overcome the possible selection bias in dual choice systems by enrolling all employees in an HMO-like program. At the same time, they can reduce the employee resistance that would probably greet a proposal for universal HMO enrollment, because they offer employees the safety valve of being able to choose non-plan providers.

Officials of some major insurers that have experimented with open-ended plans in multiple markets report that the plans appear to be reducing the rate of health care cost increases, relative to the increases for their conventional offerings in the same markets.[52] Because these plans began operations only very recently the data required for an objective evaluation are not yet available. Even PPOs. which have existed for a decade, have never been the subject of a controlled study. Some preliminary findings, however, suggest that the safety valve that makes PPOs attractive is potentially a serious weakness, one which may carry over to the newer hybrid plans.

One recent study of a PPO found that enrollees used the PPO's providers for preventive care and minor illnesses, but went outside the network about half the time for specialty care, major surgery, and hospitalization without surgery.[53] One study found a similar pattern among PPO enrollees who were actually employees of one of the providers in the PPO network.[54] While these findings are not definitive, they suggest a dilemma that may be common to both PPOs and the newer types of managed care plans. If the price for going out of plan is not punitive, enrollees may obtain much of their care outside the network; if the price is set high enough to deter outside utilization, the plan may lose its relative attractiveness.

Both solutions to the biased selection problem, higher premiums for the non-HMO plan or higher cost-sharing for using non-HMO providers, may then face the same potential barrier: the highest-risk enrollees, those for whom the greatest potential savings presumably exist, may be willing to pay much more out-of-pocket to retain free choice of providers and avoid bureaucratic restrictions. While the problem might be overcome by making the cost of unrestricted health care prohibitive, this solution may be foreclosed by the potential strain on labor relations (or, in the case of public programs, political resistance).

One other solution that has been proposed is to go to the roots of consumer resistance to managed care, the concern about quality. Some analysts argue that, because consumers have little information about the relative quality of different medical care providers, they must rely on "signals" of quality sent out by various providers, such as the use of elaborate technology or aggressive medical treatment styles.[55] If the persons with the highest expectation of requiring medical services will accept financial sacrifices to avoid managed care programs, this may be because they cannot evaluate the care offered by such programs and wish to remain free to seek out the providers who more actively signal quality. This preference might be overcome if consumers had reliable data on the actual quality of the care furnished by different providers or provider systems such as HMOs.

---

[52] Personal communication with officials of Prudential and CIGNA.

[53] Wouters, Annemarie, and James Hester. Patient Choice of Providers in a Preferred Provider Organization. *Medical Care,* v. 26, no. 3, Mar. 1988. p. 240-255. The results may not be fully representative, because the PPO studied was somewhat skewed towards primary care providers.

[54] Diehr, Paula, et al. Use of a Preferred Provider by Employees of the Preferred Provider. *Health Services Research,* v. 23, no. 4, Oct. 1988. p. 537-554.

[55] For an elaboration of this theory, see Robinson, James C. Hospital Quality Competition and the Economics of Imperfect Information. Milbank Quarterly, v. 66, no. 3, 1988. p. 465-81.

This view has led to such proposals as the "buy right" plan advanced by Walter McClure of the Center for Policy Studies in Minnesota. Under this plan, a community would collect and make available to consumers uniform data on patient outcomes from all providers. Consumers would then be in a position to determine whether the higher cost providers were actually furnishing superior care and could thus make rational purchasing decisions. The proposal assumes that the community can agree on objective measures of quality. Past efforts to develop uniform bases of comparison have been controversial. For example, the annual release by the Health Care Financing Administration of mortality data for Medicare beneficiaries in hospitals has been criticized on the grounds that numerous factors other than relative proficiency can affect the death rates of hospital patients. Highly specialized facilities may be treating the most seriously ill patients; facilities serving a low-income population may find that more of their patients have delayed medical treatment beyond the point at which they could be helped. Full implementation of the "buy right" strategy might have to wait until research can provide acceptable standardized outcome measures. Assuming that those measures can be developed, how would competition then work? Consumers would be fully informed about the relative price and quality of competing health plans, and would thus be equipped to make medical care purchasing decisions in the same way that they decide about other purchases. Proponents of competition argue that the power of the market would then compel all providers to make steady improvements in both quality and efficiency. However, if the health care market could be induced to evolve in the same way as other markets, it is not necessarily the case that the end product would be a single class of providers uniformly striving to achieve the same goals. The health care market could instead be segmented in the way that the markets for other goods and services are; there might be economy and luxury health plans just as there are economy and luxury automobiles. Improving the information available to health care consumers might mean only that buyers would be better able to distinguish between the two, not that the distinction would cease to exist. Whether Americans are prepared to accept the same price/quality tradeoffs in buying medical care that they do in buying other products is an open question.

STATEMENT OF THE GENERAL MOTORS CORPORATION

General Motors appreciates the opportunity to submit comments on two very important issues access to health care and the containment of rising health care cost. As the largest non-governmental purchaser of health care in the U.S., GM provided health care benefits to nearly two million enrollees (employees, retirees, and their families) nationwide in 1989. Thus, we have a strong interest in promoting a workable, efficient and effective health care delivery system, and we applaud this committee's efforts to improve the understanding of issues that impair the quality of health services.

GM shares the concern that access to necessary medical care is a serious problem for millions of Americans who lack health insurance coverage. Like many other large corporations, we have long provided our employees comprehensive health care benefits. We also, in our role as a payor to hospitals, subsidize the substantial costs of uncompensated care, including indigent care, and shortfalls from the Medicaid and Medicare programs. Therefore, we recognize that lack of health insurance is a serious problem.

Evidence indicates that those without health insurance coverage have a greater chance of failing to receive needed supportive medical care than persons with insurance coverage. Although the uninsured do receive significant amounts of medical care, their rates of physician and hospital utilization are lower than the insured population.

Some of the families and individuals who lack insurance coverage are particularly vulnerable: for example, pregnant women and young children, disabled children, and disabled adults and adults on welfare who wish to work or resume work. Furthermore, the Medicaid program that was intended to serve the poor fails to provide coverage for a large number of poor families.

General Motors supports reasoned efforts to expand health insurance coverage to the uninsured. We believe society ought to search for methods to reduce barriers that block access to basic health services for some Americans. However, at the same time, we must also recognize a responsibility to find ways to provide services in the most efficient and cost-effective ways, since any programs to expand health care coverage will certainly have consequences for health care costs.

In this regard, we believe it is important that participants in the market for health care services study closely the reasons why that market functions so poorly. We believe the government and the private sector needs to review constantly those tax, regulatory and private sector policies that contribute to increasing health care costs. For example, we might look at the impacts of the current tax treatment of health care benefits and reliance on employer-provided health insurance on health care utilization and prices.

ACCESS AND COSTS

In GM's view, the issues of access to health care and rising health care costs are highly interrelated. Not only is the plight of the uninsured compounded by rising health care costs, but rising health care costs make it more difficult for many to obtain health insurance coverage.

First, high and rising health care costs have deterred many small employers from offering coverage to their workers and have made coverage unaffordable for many individuals without a workforce connection. Second, rising costs in an environment of budget constraints have caused Medicaid and Medicare funding both Federal and state to fail to keep up with the medical inflation rate, squeezing the ability of these programs to serve their constituencies.

Budget constraints have also resulted in cost shifting from the public to the private sector. As government payments for Medicaid and Medicare patients fall below the costs of the services provided, the volume of uncompensated care at hospitals increases, and hospitals are forced to raise the prices charged to private payers. Exacerbating this problem for private payers are insurance reimbursement systems which allow providers to pass through expenses and profit margins. The net result is a cycle where prices are forced up for private payers.

HEALTH CARE COSTS

The outlook for health care costs is grim: Between 1960 and 1988, total U.S. expenditures on health care increased from $27 billion, or 5.2% of Gross National Product (GNP), to $500 billion, or 11.2% of GNP. Current forecasts predict a health care growth rate averaging 11.7% during the next decade. At that rate, the health care share of GNP would increase to 17.6%, or $2 trillion, by the year 2000.

There are clearly many factors that contribute to these rapid increases in health care costs. Some, such as the general aging of the population which has increased the incidence of chronic disease, are not particularly amenable to policy intervention. Others relating to the incentives and disincentives built into the current health care delivery system may be more amenable to policy intervention. However, others such as administrative costs, inappropriate or unnecessary uses of technology and services, and medical prices may be responsive to better management policy.

GM COST CONTAINMENT INITIATIVES

In 1989, GM spent almost $3 billion on health care in 1989, and we project our health care bill to increase by 15% per year. This trend is alarming because, as health costs rise, our ability to fund other corporate objectives declines. Furthermore, we are finding ourselves at a disadvantage relative to some of our competitors who do not have the same level of health care responsibilities. For example, about one-third of GM's health care costs are related to retirees, whereas the U.S. operations of foreign-based vehicle manufacturers are not significantly burdened with retiree costs.

Because we are concerned about the rising trend in health care costs, GM has initiated a number of steps to curb the rate of increase in our own health care costs. To this end, we have placed special emphasis on the development of cost-effectively managed care plans and utilization management techniques that enhance quality and control cost. We also have supported health resource planning at the local, state and national levels as a means of controlling hospital capital expenditures and preventing excess capacity through the unnecessary proliferation of providers and services.

While efforts to sly the rate of increase of health care expenditures have had mixed results, we have learned a great deal about issues such as: the driving factors behind our health care costs; the response of providers, carriers and enrollees to such initiatives; and, perhaps most importantly, the strengths and weaknesses of these efforts. GM remains committed to the concepts of managed care embodied in Health Maintenance Organizations, Preferred Provider Organizations and utilization management activities, and we continue to seek ways to improve the effectiveness of these programs.

HEALTH REFORM STRATEGIES

Going forward, we believe that a broader utilization of managed care techniques in government programs will increase the probability that they provide health care cost-effectively. Additionally, GM supports ongoing research into the relationships between medical treatments and medical outcomes and the development of clinical practice standards. Such information has potential applications for strategies to control the costs of medical malpractice, to assist in the purchase of high quality, necessary health care services, and to reduce unnecessary utilization.

There are many opportunities to control health care costs that warrant additional exploration. It is GM's opinion that the nation's current priorities should be to gain further experience with what works and what does not work to reduce the rate of increase in health care costs. Without such information, there is a risk that actions taken to fill the gaps in the nation's health care delivery system could aggravate our current cost problems.

Therefore, we encourage Congress to support realistic health care cost containment strategies. We also recognize a need to find a timely and realistic solution to the access problem. However, given the complexity of this problem, it may take some time to develop workable and effective solutions that meet the special needs and requirements of this country. Therefore, we believe any strategy to increase health care coverage should be phased in over an appropriate time period.

Some of the proposals to aid the uninsured are excessively broad in scope and would likely be quite expensive. In some cases, they would involve major structural and philosophical changes to our current public/private mix of service delivery. For example, current proposals to mandate a minimum level of insurance benefits for all employed workers could be highly inflationary because of the lack of any realistic mechanisms to control costs. In addition to the known costs, there are unknown costs, such as the risk that the increases in utilization stimulated by such programs will put significant upward pressures on health care prices.

In contrast, a narrowly focused approach would build upon existing programs and could offer relief to those most in need without ruling out more comprehensive system reforms later—if warranted. As a starting point, efforts to extend Medicaid coverage to all households with incomes below the Federal poverty line should continue to be explored. We agree with the Business Roundtable, which has suggested that Congress consider the extension of Medicaid to all children under 18 years of age who live in households with incomes below the Federal poverty line. In the future, expansion of Medicaid coverage to all remaining persons living in poverty may be appropriate.

The effectiveness of other strategies to promote higher rates of insurance coverage among other target groups is difficult to estimate—in part because of the sparsity of information about the uninsured. Available information suggests that of the 31 million without health insurance at any one time, only four to five million are chronically without health insurance, with considerable turnover among the others. Reliable information about the total number of persons without health coverage over the course of a year—or the length of time they are without coverage—is not available. Thus, the costs of covering the uninsured could be considerably higher than currently anticipated.

Employees of small firms are less likely to have health insurance coverage than employees of large firms; hence, actions to reform the small group health care marketplace—such as risk pooling to reduce the costs of coverage for persons without a large group affiliation are appealing in concept. Unfortunately, it is difficult to project the excess risks—and associated costs—of such plans without more information about potential beneficiaries. Such information is crucial to the development of well-targeted programs to address the broader range of access problems.

CONCLUSIONS

In conclusion, the problems facing our nation's health delivery systems are very complex. GM shares the concern that the lack of health insurance is impeding access to necessary medical care for many Americans, and we support reasoned efforts to expand coverage for the uninsured. However, rising health care costs represent another important issue requiring public and private sector attention, and solutions to access problems should not conflict with efforts to curb the increase in health care costs. We need to understand clearly why the market for health care services functions so poorly and the options available to the public and the private sector to make that market function more effectively.

Therefore, GM recommends that solutions to the access problem should be narrowly defined in the short-term and focus on the most vulnerable populations who lack health insurance coverage. More information—both about the identity and problems of the uninsured and about effective cost containment strategies—is needed to develop a more comprehensive strategy.

In the long-run, our goal should be to have a quality health care delivery system in this country that is accessible to all and functions cost-effectively. Achieving this goal will require further expanding the concept of access to encompass issues such as the distribution of providers (geographic, by specialty, etc.) and the ability of users to obtain services in a timely manner. It also will require all of us to assume greater responsibility to support such a system by being judicious health care consumers.

THE "HEALTH FOR BUSINESS" PLAN

E. FRANK GRIFFIN

THE "HEALTH FOR BUSINESS" PLAN IS A METHOD BY WHICH BUSINESSES AND ORGANIZATIONS CAN CONTROL AND REDUCE THEIR HEALTH CARE COSTS IN HALF THROUGH DIRECT OWNERSHIP OF MEDICAL FACILITIES AND STAFF.

INTRODUCTION

The author is a former acute care hospital owner who had an opportunity to penetrate the closely guarded secrets of the exceedingly profitable business of the health care delivery system.

The health care delivery system has two basic components- the healing practice of medicine and the profitable business of medicine. The "HEALTH FOR BUSINESS" plan addresses the business of medicine while maintaining the quality of the healing practice of medicine.

In an editorial, Lee Iacocca said, "We've waged a war on health care costs for more than 10 years and lost it..." He is right. Health care cost containment has been a TOTAL failure.

Much effort has been expended writing rules and regulations in an attempt to control costs in the artificial economic environment of the health care delivery system. An even greater effort has been expended in trying to circumvent those rules and regulations. The "HEALTH FOR BUSINESS" plan replaces the artificial economic environment and its regulations with a free enterprise market solution.

The "HEALTH FOR BUSINESS" plan works because it removes the waste by taking out the middlemen- insurance companies, hospitals and doctors- and also by putting health facilities and staff under the direct ownership of the American consumer/patient, the businesses and their employees. This assures a guaranteed patient base for the successful operation of the health care delivery system.

For large businesses, a reduction of 50% of their current health care costs is achievable. Since small businesses pay a health care premium penalty for their size, a greater reduction of up to 66% is achievable.

This plan can be implemented without any Government funds, without new taxes and without new laws. However, with tax incentives, it can be used to reduce the financial impact on businesses employing the 26 million working uninsured. Fewer Government funds would then be required for the 11 million non-working uninsured.

The "HEALTH FOR BUSINESS" plan shows how control through ownership can substantially reduce the cost of health care and, at the same time, maintain health care quality.

UNDERSTANDING THE BUSINESS OF HEALTH CARE

Eisenhower warned of the waste and power excesses of the military-industrial complex. Today the military-industrial business represents only $ 300 billion per year or 6% of the GNP. Yet the medical-industrial business is $ 600 billion per year and is 12% of the GNP. And these health care costs are projected to increase more than double to $ 1,350 billion in the next 10 years. Eisenhower's warnings apply even more to the greater waste and excessive costs of the runaway health care bill.

It's time to stop the rape of the American consumer/patient by the medical-industrial conspiracy.

UNDERSTANDING THE HOSPITAL BUSINESS

The hospital business is an enigma. For example, an acute care hospital that is 80% occupied by patients is 50% gross profitable - after hospital expenses. This figure excludes hospital loss leaders like an emergency room, maternity and government programs. This level of profitability is incomprehensible to a rational business man who experiences gross profits in the 5% to 15% range.

The paradox in the hospital business is that if it's so profitable, why are so many hospitals going bankrupt? The answer is that hospital insiders recognized the fantastic profits in the 1970's and began buying hospitals. Many hospital companies in their greed overpaid for the hospitals and saddled their companies with excessive debt. When business dropped off (i.e. fewer patients), these companies were unable to meet their interest payments - which in several cases amounted to over $100 million per year.

Some hospital companies were formed with each hospital as a separate, independent subsidiary. This allowed the parent company - which had secured its debt with stock - to go bankrupt without any real or personal property assets. This allowed the managers to continue to draw their lucrative salaries and fringe benefits during the lengthy bankruptcy proceedings.

Currently, hospitals in much of Southern California bill their patients an average of $2,000 per day. This includes room and board and all services and supplies for an average 5 day stay. If the patient requires quadruple heart by-pass surgery, the average patient day charge will be over $15,000 per day. These are hospital charges only and do not include any separate doctor billings.

Even a one day outpatient surgery bill can be enormous. A patient went into the hospital for outpatient foot surgery by a podiatrist - not a fully qualified M.D. The podiatrist's bill for 3 hours of surgery was $7,000. The hospital bill for coming in in the morning and leaving that same afternoon was for $3,000.

The acute care hospital business is different from every other type of business in many strange ways. These differences are very hard to understand - even by sophisticated business men. First, the hospital is not like a hotel where anyone can check in. The hospital is more like an exclusive club with very limited membership. This membership is the group of admitting physicians who are registered on staff and permitted to practice in the hospital. The patient is not the customer of the acute care hospital. The admitting physician is the customer. Unlike the hotel, the patient cannot check into an acute care hospital. The admitting physician must check the patient into the hospital. So we may think of the admitting physician as the customer of the acute care hospital and, for distinction, the patient may be thought of as the physician's client.

Consider then, the strange relationship between the acute care hospital business, the admitting physician/customer and the admitting physician's client - the patient. First, the admitting physician is not an employee of the hospital, is not paid by the hospital and is not supervised or directed by the hospital. This is the typical relationship between a business and its customer. But then things start to get strange. The admitting physician/customer is allowed to use very expensive medical equipment and facilities(operating rooms) belonging to the hospital business - but the hospital does not charge the doctor for this use. Instead, the bill is sent to the admitting physician's client - the patient.

The hospital's profitability depends on having the maximum number of beds occupied by patients. In hospital parlance, this is called census. Thus, when 80% of a hospital's beds are occupied by patients, the hospital is said to have an 80% census.

Since the customer of the acute care hospital business is the admitting physician - How does the hospital market itself? In most places, it is illegal for a hospital to pay a referral fee to an admitting physician for putting a patient in the hospital. This is the fundamental problem of the hospital business. How to control the admitting physician so the he will put his patients in that particular hospital. Hospitals use many methods to accomplish this without blatantly appearing to violate the law.

The admitting physician is given incentives both above and below the table. A typical method of transferring cash from the hospital to the doctor is to have the doctor perform a service for the hospital and then overpay the doctor for that service.

A typical area for performing this service is called utilization review. One method that doctors use to increase their income is to prescribe lucrative procedures and tests that the patient does not need. This has been known for a long time and hospitals are scrutinized for the services and tests a doctor orders for his patient. Admitting physicians are then contracted to perform utilization review on the performance of other doctors in ordering services and tests on their patients. How valuable the admitting physician is in providing patients to the hospital will determine how much he is overpaid for the service. This then becomes a means for the hospital to compensate the admitting physician in a semi-legal fashion for putting his patients in the hospital. Utilization review became necessary to stop doctors from ordering unnecessary tests just to make money.

Overutilization is done by doctors to increase their income. But overutilization is also done by some patients who see the doctor unnecessarily or for invalid reasons. Both of these overutilizations increase health care costs.

The "**HEALTH FOR BUSINESS**" plan solves these problems through ownership and management control.

UNDERSTANDING THE ARTIFICIAL ECONOMIC ENVIRONMENT OF THE DOCTOR BUSINESS

This brings us to the business end of the doctor/patient relationship. When a patient gets sick, he goes immediately to his physician for health care service. He typically does not ask the doctor if the tests are necessary or how much they will cost. This is very different from the way the patient buys other goods or services. In other buying decisions, price is a very influential element in the process.

So, essentially, physician and hospital services do not operate in a free market environment. In fact, in addition to not shopping for minimum cost, the patient is further isolated from the health care cost by the third party payor - the insurance company.

In economics, there exists a relation between supply and demand called the price elasticity of demand curve. For most normal cases, this means that as the demand for a product or service increases, the price increases. As the price increases, other suppliers step in to increase production and thereby drive the price down.

However, the supply/demand curve does not work this way to reduce prices in health care. In fact, changes that should bring prices down work the opposite way and increase prices. For instance, if the number of doctors increases, you would think that price competition would bring doctor charges down. This is not so - prices increase. If the number of hospital beds increases, you would think that hospital charges would go down. This is not so - hospital charges go up. The artificial economic environment of the health care business violates the economic price elasticity of demand curve. Every factor which should act to reduce health costs, actually acts to increase health costs.

There is an inherent conflict of interest in professional advice given by the person who is to perform the advised service. So a doctor can essentially create the demand for his own services. The more lucrative procedures the doctor orders, the higher his income will be.

The **"HEALTH FOR BUSINESS"** plan solves these problems by ownership of the staff model HMO which provides incentives for minimizing unnecessary expenses.

UNDERSTANDING THE INSURANCE BUSINESS

In most cases, health care costs are submitted to insurance companies for payment. The insurance company (or the government in the case of Medicare or Medicaid) must process the claims. The cost of claims processing (as well as all other costs of doing business) is in the health insurance premium. This includes the doctor's claims administration staff as well. Claims administration costs have been estimated at over $21 billion per year.

The insurance company must monitor the claims for fraud. Aetna Life Insurance Company estimates fraudulent claims at 10% or $60 billion per year. The "rolling labs" fraud in Southern California bilked insurance companies out of $100 million.

Medicare was billed and paid to a Culver City, CA woman $40 million for adult diapers that were never purchased.

Insurance companies also monitor claims for excessive charges for procedures, overutilization and unbundling.

In the **"HEALTH FOR BUSINESS"** plan there are no claims forms, no cost of claims administration and no fraudulent claims to worry about. This eliminates the $60 billion for fraud and the $21 billion for claims administration.

UNDERSTANDING THE "HEALTH FOR BUSINESS" PLAN SOLUTION

This brings us to the question - What can be done to reduce health costs? The biggest cost reduction can be achieved by eliminating the waste in doctor and hospital charges. How can this be done? Many attempts at health care cost containment have been made over the years. These have failed. Health care cost increases have averaged between 10% and 20% for years - depending on type of coverage.

Since cost containment has failed - What's left. Well, the answer is certainly not a government program. We have plenty of examples of what a disaster that would be. The answer is to get control of health care costs by eliminating excessive profit. How can this be done? The way to get control is through ownership of hospitals and HMO's.

Who would own the hospitals and HMO's? Since business pays a large share of the health insurance premium, the hospitals and HMO's can be owned by one large business or several smaller ones. The purchase could be made by the employee pension fund. This idea was originated by Kaiser in the 1930's and is still fundamentally the best solution to health care cost control.

As an example, consider a business large enough to implement this plan. These same principles apply to ownership by several small businesses but it is easier to illustrate with one owner.

The Health Care Foundation (consisting of hospitals and HMO'S) would be owned by the company stockholders, the employees and unions, and the doctors and medical staff. The current health insurance premiums would be the source of income to the Health Care Foundation. A portion of the profits of the hospital and HMO would be used to offset and reduce the health insurance premiums. Another portion of the profits would be used to reward the doctors and medical staff for minimizing expenses. This could be done through stock options and bonuses. Thus a doctor would maximize his enhanced income by minimizing expenses. This could be done at a level where the doctor would not feel the need to limit quality care but also would not have an incentive to prescribe unnecessary care.

There are also some intangible fringe benefits from this form of ownership. There would be less of an adversary relationship between the doctor and patient. They would both be employees of the same organization. This would tend to reduce malpractice suits and malpractice insurance premiums.

Hospitals sometimes don't get their expenses met on government programs like Medicaid. To cover these expenses, the hospitals sometimes result to cost shifting. Cost shifting means putting hidden charges on the bills of private insured patients to cover expenses that the government won't reimburse for its patients. This problem would be identified and handled by the privately held foundation.

The Foundation size would be scaled to the size of the patient base in the businesses that owned it. This solves the fundamental problem of the health care business - control of the patient base. Therefore, the money needed for marketing and covertly paying physician's for admitting patients would no longer be an added health care cost.

Also, the health insurance premium could be discounted for employees with reduced health risks. The discounts could apply to not smoking, not being overweight etc.

This method of ownership to achieve control over health care costs can be extended to organizations other than businesses. Government legislation will not bring health care costs down, but control through ownership will.

UNDERSTANDING THE EASY INITIAL IMPLEMENTATION OF THE "HEALTH FOR BUSINESS" PLAN

The **"HEALTH FOR BUSINESS"** plan can be implemented in simple, gradual and easy to understand steps.

Most businessmen are concerned about getting involved with the health care business. The "mystique of medicine" has been propagated by doctors for years, for their own ego's and to maintain an aura of God-like infallibility. Hospital companies and hospital administrators also promote this "mystique" to hide their own incompetence.

Fortunately, the **"HEALTH FOR BUSINESS"** plan can be implemented in very easy and gradual steps. As an initial first step, the company's current health plan would remain entirely unchanged. A stock purchase of a local hospital could be made. There would be no participation by the business in the management of the hospital. The business would be the sole stockholder and as such would only be required to elect the hospital's Board of Directors once a year. As the sole stockholder, the business would be entitled to all of the hospital's profits.

The business could elect to recommend the hospital to a certain geographical group of employees on a test basis. Based on the results of the test operation of the hospital for a certain period of time, the business could elect to discontinue the test project or proceed with further implementation.

The hospital consists of two parts, the real property of the land and buildings, and the securities interest of the Operating Company. The business could purchase only the Operating Company or both the Operating Company and the real property.

THE "HEALTH FOR BUSINESS" PLAN

PROJECTED COST SAVINGS

	LOW	HIGH
FRAUD	5%	15%
PAPERWORK	4%	20%
MALPRACTICE		
PREMIUMS	2%	3%
DEFENSIVE MEDICINE	8%	15%
OVERUTILIZATION		
TECHNOLOGICAL	5%	10%
FUN & PROFIT	8%	12%
LAYERS OF PROFIT REMOVED		
INSURANCE COMPANIES	5%	20%
ACUTE CARE HOSPITALS	10%	50%
DOCTORS	15%	45%

NOTES:

The cost reduction percentages do not total up to 100% because they apply individually to the three separate billing entities- insurance companies, hospitals and doctors.

The fraud percentage can be attributed from any billing source to any payor.

The acute care hospital profit also includes cost shifting from underfunded programs such as Medicare, Medicaid and discounted rates to HMO's.

The cost of the administrative and bureaucratic support system is much higher in the United States than elsewhere. One study shows that more than $130 billion- 23% of U.S. health care spending- goes to managers, administrators, insurers, marketers, lawyers and other paper-pushers, compared with only 13% in Canada.

CURRENT GOVERNMENT EFFORTS

Many national business and political leaders support the idea that there should be some form of national health insurance. Based on the experience of the recently proposed health coverage attempts, the prospects for national health insurance appear highly unlikely.

Governor Deukmejian, here in California, sponsored AB 350 to mandate health care coverage for business. Small businesses protested the cost impact very loudly. So that when the Task Force report giving the cost figures was submitted to the Governor, he disavowed any further support. The legislature is attempting to find cost effective alternatives.

Also, on the national level, the Pepper Commission report indicating $86 billion was required to cover the 37 million uninsured was submitted, it was rejected by both Congress and President Bush.

President Bush has asked the Domestic Policy Council to prepare health care alternatives for evaluation in the Fall.

The **"HEALTH FOR BUSINESS"** plan has been submitted to the Senate Finance Committee to be read into the Congressional Record when health care hearings resume again. The **"HEALTH FOR BUSINESS"** PLAN has also been submitted to Governor Deukmejian, the Pepper Commission and the White House Domestic Policy council.

RECOMMENDED GOVERNMENT SUPPORT

Although the **"HEALTH FOR BUSINESS"** plan can be implemented without any government participation, there are some steps that can be taken to encourage and hasten the process. These are:

1. Allow doctors to practice as corporate employees under the supervision of other doctors.
2. Provide tax incentives to small businesses for providing health coverage for the working uninsured.
3. Provide umbrella coverage to an employee who transfers to another company.

STATEMENT OF HEALTH POLICY COALITION

[March 8, 1990]

HEALTH POLICY AT THE CROSSROADS—NEW DIRECTIONS FOR THE INSURED AND UNINSURED

I. New Directions in Health Care: The Patient Choice Alternative

Health care in the United States is at a crossroads. The road we are currently on is inadequate, costly and perilous:

—Fifteen percent of the average American worker's compensation—wages and benefits—now goes to pay for health care. That's a five-fold increase in about 20 years. (See chart.)

—The costs of health care for taxpayers, government, employers, employees and patients are high and continue to increase substantially.

—The medical community and patients are increasingly burdened with outside intervention by public and private payers.

—Approximately $150 billion of our annual health care expenditures are wasted. (See chart.)

—Public and private health insurance programs still largely encourage waste, rather than reward quality and greater productivity.

—America spends twice as much as Japan on health care, and 50% more than any other major country—nearly 12% of GNP, $600 billion in 1989. (See chart.)

—None of these other countries has 17% of the population (37 million in the U.S.) uninsured.

—Medicare, Medicaid and private health insurance plans face ominous short-term and long-term financial problems.

—The elderly are often without protection against the high costs of long-term care.

A new direction for health care in the United States is urgently needed. The most promising new direction is to rebuild our Nation's health care system to maximize patient choice. One example of where this is being done is Cleveland Health Quality Choice.

II. Cleveland Health Quality Choice

Cleveland Health Quality Choice has been initiated by ten CEOs of major American organizations—Ameritrust, BP America, General Electric Lighting Group, LTV Steel, Nestle Enterprises, Ohio Bell, Parker Hannifin, Reliance Electric, Sherwin Williams, and Jones, Day, Reavis & Pogue. These ten CEOs are personally stepping forward to make an effort to reform our health care system.

Beginning with this core company involvement, Cleveland Health Quality Choice will grow into a broad, regional initiative based on three principles:

1. *Patient Choice.* Provide employees and patients with a choice in how much of their compensation and income goes to health care. They presently have little choice.

2. *Quality.* Improve the measurement of quality outcomes and provide patients and their doctors with information on quality outcomes and medical uncertainty so that patients receive the best value for their health care dollars.

3. *Incentive Reform.* Change the incentive system for doctors and hospitals so that patient choices on the cost and quality of their health care are rewarded. Today, the insurance reimbursement system pays for procedures regardless of results and costs. We need to become more efficient and to pay for what we do for patients, not for what we do to patients. We must move from a pay-for-service system to a reimbursement system based upon quality, efficiency and results.

Cleveland Health Quality Choice is proceeding on two tracks at the same time. First, employers are implementing, now, health insurance benefit plans that allow employees and their families to choose their health care providers using the best quality/cost information that is available today. Second, to improve the information and feedback process, it is developing in cooperation with local hospitals and doctors a community-wide quality/cost measurement system.

The Health Policy Coalition is willing to work with Congress to develop and implement patient choice alternatives and to pursue the new directions in health care policy we so urgently need. If we can redirect the $150 billion that is wasted annually on unnecessary or ineffective medical care, we can preserve health benefits for the 210 million Americans that currently have them, and improve access for those that do not.

In order to help improve access now, Congress can enact the Coalition's proposed Small Employer Purchasing Groups Bill (the "COSE Bill").

III. Small Employer Purchasing Groups Bill

A. Rationale

First, the majority of the uninsured are associated with small employers.

Second, the Council of Smaller Enterprises is a small employer purchasing group that works in Cleveland for over 120,000 people. Properly crafted Federal legislation can help spur the formation and expansion of similar programs in other communities, and help reduce the number of uninsured affiliated with small employers

Third, no Federal funds are required.

Fourth, there are a number of non-essential Federal and state laws that can be streamlined to help make essential health insurance available to millions of Americans.

Fifth, employees should not directly, or indirectly through hidden payroll taxes or mandates on employers, be denied a choice in the amount of their compensation that goes to pay for health benefits.

B. Specific Provisions

The COSE Bill proposes that Federal legislation be enacted to facilitate the establishment and operation of COSE-type small employer plans called Small Employer Purchasing Groups. The COSE Bill uses as models the COSE experience, and experience under the Risk Retention Act. The following specific provisions would encourage and permit such Groups to provide affordable health coverage to the small business market by organizing the diverse businesses into one group, reducing administrative and acquisition costs, and facilitating negotiations with insurers and providers:

1. *Definition.* The COSE Bill would only apply to "Small Employer Purchasing Groups" ("Groups"), which are defined to be (a) associations of businesses with less than 500 employees, including the self-employed, that (b) are not established by and are not controlled by an insurance company or any person affiliated with an insurance company doing business with the Group. See January 11, 1989 Department of Commerce Discussion Draft, Liability Risk Retention Act Amendments ("Discussion Draft"). Thus, a Group must, like COSE itself, be controlled by small employers, the buyers, which has been important to COSE's success. However, buyer control is a conservative approach and will restrict the number of small employer groups that are formed.

2. *Insurer.* The Group's insurer would have to meet certain requirements, similar to some of those found to be appropriate under the Risk Retention Act, such as: (a) provide a fully or partially insured health plan of any type selected by the Group; (b) meet federally-set minimum capital and surplus requirements; (c) declare which state is the insurer's principal place of business, maintain an office in that state, and have members in that state; (d) provide certain information to regulators in every state in which the Group has members; and (e) not sell to individuals but only to members of the Group. See Discussion Draft.

3. *Exemption from Multi-State Requirements.* The Group and its insurer would be allowed to substantially lower administrative costs and costs related to health benefits the Group does not consider essential or affordable by being exempted from state laws on (a) mandated benefits; (b) mandated providers; (c) rate approval (group health insurance rates are rarely, if ever, really regulated); (d) policy forms, and (e) insurance agent and broker licensing (except in the state of the Group's principal place of business). The substantial claim and administrative savings resulting from these exemptions would be used to (a) subsidize the elimination or reduction of pre-existing condition exclusions (see Part 10, below), as well as to (b) make the health insurance affordable.

4. *Additional Incentives for Employers To Begin Health Insurance Coverage.* Small employers that currently do not provide health insurance would be given additional incentives to begin coverage: (1) a five-year waiver on state premium taxes, which would lower costs but would not reduce state revenues because there is no coverage now; and (2) a five-year waiver of COBRA continuation of coverage requirements, which would actually expand coverage since there is none now. The state premium tax amount would be charged and used to subsidize the elimination or reduction of pre-existing condition exclusions (see Part 10, below).

5. *State Opt-Out Alternative.* Since the exemptions from mandated benefits and other state laws in (3) and (4) may be controversial, each state alternatively could be allowed to opt-out of the exemptions. However, this alternative is likely to be less effective in reducing the number of uninsured Americans.

6. *Access to Quality Measurement Data.* Groups would specifically be allowed access to the quality measurement data that will be produced under new Federal initiatives. Access to this data will materially assist patients, employees and employers to obtain better quality health care at more affordable costs.

7. *Annual Notice to Employee of Costs.* Employers would notify employees annually in their W-2s or otherwise of the total costs of their Group health insurance, including both the employee and employer paid amounts. Employee access to the total cost of their health insurance will give employees some of the information they need to influence the amount of their compensation that goes to health care, and to help them keep their health insurance affordable.

8. *Self-Employed Premium Deduction.* The self-employed would be allowed the same 100% deduction of health insurance premiums available to corporations.

9. *COBRA and ERISA Reporting.* In order to remove ambiguities in the law, and to encourage the formation of Groups, the COSE Bill would (1) make explicit that each employer insured through Groups is responsible for complying with COBRA and ERISA's reporting requirements, and that none of the penalties under those laws apply to a Group; and (2) exempt Groups and employers insured through Groups from pending and future laws that would impose filing fees on ERISA form 5500.

10. *Pre-Existing Conditions and Federal Insurance.* The COSE Bill will help alleviate the problems created by pre-existing condition exclusions by establishing a reinsurance pool funded by (a) some of the savings from mandated benefit law exemption and (b) the redirection of the amount of the state premium tax for employers that begin providing health insurance.

The details of the subsidy needed and the changes that can be made in pre-existing condition exclusions are complex, and could be provided if the Subcommittee is interested further in the COSE Bill.

C. METs

The COSE Bill deliberately takes a conservative approach to uninsured Multiple Employer Trusts ("METs") by not proposing to relax the solvency requirements for Multiple Employer Welfare Arrangements in Section 514(b)(6) of ERISA. See generally Buchman, "Insured and Uninsured METs—Current Problems," 16 Connecticut L. Rev. 453 (1984).

We suggest, however, that the Subcommittee:

(1) propose easier means for fully-insured METs to invoke the ERISA preemption included in the current law,

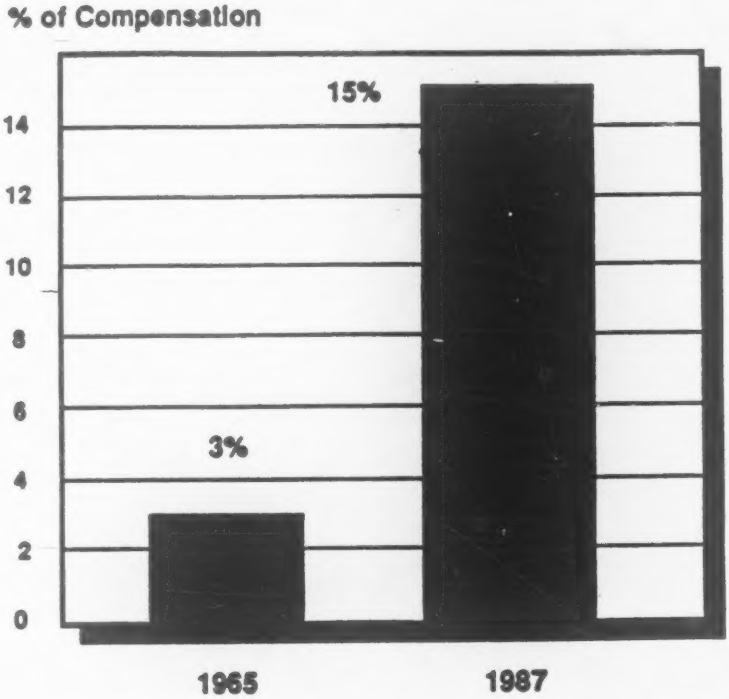
(2) explore practical impediments to insured and uninsured METs under Section 514(b)(6),

(3) consider alternative means of assuring the solvency of METs, and

(4) review related issues in the recent Second Report to Congress on the Liability Risk Retention Act that the Department of Commerce.

If the Subcommittee is interested in exploring any of these issues, the Coalition would be pleased to provide assistance.

How Much of an Employee's Compensation Goes to Health Care

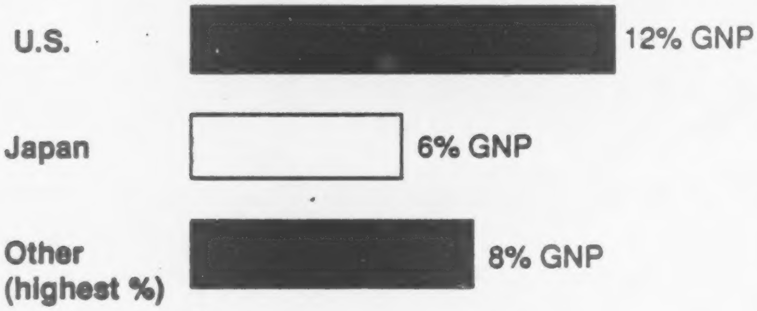


Source:
Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

U.S. HEALTH CARE COSTS
vs.
OTHER MAJOR COUNTRIES

- ✓ 100% more than Japan
- ✓ 50% more than any other major country
- ✓ 37 million uninsured (none in other countries)

HEALTH CARE COSTS (% GNP)



Source: Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

THE RANGE OF MEDICAL UNCERTAINTY:
A $150 Billion Opportunity

Eugene Robin, M.D., Stanford University:

> "America's . . . annual healthcare bill could be cut by 30 percent . . . if unnecessary medical and surgical tests, treatments, and procedures were discontinued."

David Eddy, M.D., Duke University:

> "We are wasting from 10% to 30% of our resources . . . in terms of doing things that are either not worthwhile at all or are relatively inefficient compared to other things we might do."

Arnold Relman, M.D., *New England Journal of Medicine*:

> "I have long held the opinion, based on wide experience as a consultant and teacher in internal medicine, that more prudent choices by physicians could probably reduce expenditures for drugs, tests, procedures, and the use of hospital facilities by at least 15 to 20 percent—without any loss of medical effectiveness. Lack of available information about the relative effectiveness of new technology and inadequate education of practitioners are partly to blame for this overutilization of medical resources, but the economic inducements of an insurance-based, fee-for-service reimbursement system surely play an important role."

Source: Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

STATEMENT OF HEALTH POLICY COALITION

[May 9, 1990]

I. A PRACTICAL APPROACH TO EXPAND COVERAGE FOR THE UNINSURED—THE HEALTH POLICY COALITION'S "COSE BILL" FOR SMALL EMPLOYERS

A. Summary

Congress can enact legislation that requires *no Federal funds,* and that will help make health insurance available for the first time to millions of American workers and their families:

> *The Small Employer Health Insurance Availability and Affordability Act (the "Coalition's COSE Bill")*

In Cleveland, the Council of Smaller Enterprises of the Greater Cleveland Growth Association ("COSE") operates a purchasing group that makes health insurance available and affordable to 7,000 small employers and over 120,000 employees and their dependents. Fully 25% of COSE small employers started providing health insurance because COSE made coverage affordable.

The Coalition's COSE Bill will significantly lower the cost of small employer health insurance and therefore make it possible for many small employers to provide health insurance to their employees by:

1. Encouraging the formation of private Small Employer Purchasing Groups, like the COSE program in Cleveland.
2. Using as a model for small employer health insurance the Risk Retention Act of 1986, which has been successful in making liability insurance more available and affordable.
3. Privately funding reinsurance to reduce pre-existing condition restrictions and provide "stop loss" coverage by charging Group members approximately the amount of state premium taxes.
4. Redirecting state premium taxes for newly covered groups, which range up to 4%, to help purchase reinsurance. Only newly covered groups would be entitled to the waiver, so that the waiver will not reduce existing state tax revenues.
5. Allowing small employers and employees to choose the combination of benefits that best meets their needs without regard to state-mandated benefit laws, like most large employers currently can do.
6. Allowing each state to choose whether or not to permit Small Employer Purchasing Groups to offer health insurance to small employers, employees and their families.

B. Rationale

There are a number of specific problems and opportunities that can be addressed in order to significantly reduce the number of uninsured Americans. The problems include:

1. The unavailability of affordable health insurance to small employers is a major reason why there are so many uninsured Americans. Approximately 70% of the uninsured are either employed or dependents of employees, and most of the employees work for small employers. EBRI, "A Profile of the Non-elderly Population Without Health Insurance" 1, 5, 7 (May 1987).
2. There are no significant Federal or state funds available to meaningfully address the uninsured problem.
3. In today's competitive environment, employer mandates are in reality mandatory payroll taxes on employees. The average American worker now pays 15% of total compensation for health care. (See enclosed chart.)

There are practical opportunities to significantly reduce the number of uninsured Americans by making small employer health insurance more affordable and available, without government funding. The Coalition's COSE Bill is specifically designed to take advantage of these opportunities to significantly lower the cost of small employer health insurance by:

First, encouraging the formation of private Small Employer Purchasing Groups, like the COSE program in Cleveland. The COSE group purchasing program for small employers "save[s] about 35% over the cost of comparable coverage" for its small employer members. House Committee on Small Business, "The Health Insurance Problem: Alternative Strategies to Expand Coverage Among Small Business," p. 31 (Dec. 1987).

Second, using the Risk Retention Act of 1986 as a model for small employer health insurance. The Commerce Department recently reported that the Risk Retention Act has been successful in making liability insurance more available and affordable. Department of Commerce, *Liability Risk Retention Act of 1986 Operations Report* (1989) ("Operations Report"). This success can be extended to small employer health insurance.

Third, pre-existing conditions and large losses for individual employees or family members can make health insurance impractical and unaffordable for a number of small employers. Privately funding "stop loss" reinsurance through a charge to all purchasing group members will help alleviate these problems.

Fourth, redirecting state premium taxes for newly covered groups to help pay for "stop loss" reinsurance provides an opportunity to make small employer health insurance more affordable and available, without reducing state tax revenues. Only newly covered groups would be entitled to the state premium tax waiver, and these groups currently do not pay state premium taxes.

Fifth, at least nine states have already passed or are considering legislation that tailors mandated benefit laws to the needs of small businesses and their employees. "States Tailor Benefit Laws to the Needs of Small Businesses," *Washington Post*, p. 5 (April 16, 1990). In Virginia and Washington, for example, it is estimated that such legislation will reduce the cost of small employer health insurance by 33%-40%. "Affordable Health Benefits," *Business Insurance*, p. 8 (April 9, 1990).

Thus, allowing employers and employees to choose the combination of benefits that best meets their needs without regard to state-mandated benefit laws also will significantly lower the cost of small employer health insurance. There may be as many as nine million Americans without health insurance solely because of more than 600 state-mandated benefit laws. *Wall Street Journal*, p. B1 (Dec. 28, 1988). None of these laws, however, outweighs the importance of making health insurance more available and affordable to the uninsured.

Finally, no state would be required to permit Small Employer Purchasing Groups to offer health insurance to small employers and their families. Each state could make its own choice.

II. SPECIFIC PROVISIONS OF THE COALITION'S COSE BILL

1. *"Small Employer Purchasing Groups," or ("Groups")*, are defined to be: (a) associations of businesses with less than 500 employees, including the self-employed, that (b) are controlled by the small business buyers, like the COSE program. Control by the small business buyers has been an important element in the COSE program's success. Control of purchasing groups by buyers is also one of the recommendations in the 1989 *Operations Report* regarding the Risk Retention Act.

2. *Reinsurance Funding.* Each member of the Small Employer Purchasing Group would be charged approximately the amount of state premium taxes so that the group could purchase "stop loss" reinsurance. This charge would be made possible by (a) using a portion of the savings from the waiver of state-mandated benefit laws and (b) by redirecting state premium taxes for employers that begin providing health insurance. As noted, these employers currently do not provide insurance, so there would be no loss of tax revenues to the states.

3. *Incentives for Employers To Begin and To Continue Health Insurance Coverage.* As in the Risk Retention Act, the Group and its insurer would be allowed to substantially lower administrative costs and costs related to health benefits the Group does not consider essential or affordable by being exempted from certain state laws, such as (a) mandated benefits, (b) mandated providers, (c) rate approval (group health insurance rates are rarely, if ever, really regulated), (d) policy forms, and (e) insurance agent and broker licensing (except in the state of the Group's principal place of business).

The substantial claim and administrative savings resulting from these exemptions would be used to (a) provide "stop loss" reinsurance purchased by the Group, as well as to (b) make health insurance more affordable.

4. *State Opt-Out Alternative.* Each state could choose whether or not to permit Small Employer Purchasing Groups to offer health insurance to small employers and their employees in the state by passing legislation declining to permit Small Employer Purchasing Groups to do so.

5. *Insurer.* The Group's insurer would have to meet certain requirements, similar to some of those found to be appropriate under the Risk Retention Act, such as:

(a) provide a fully or partially insured health plan of any type selected by the Group;

(b) meet federally-set minimum capital and surplus requirements;

(c) declare which state is the insurer's principal place of business, maintain an office in that state, and have members in that state;

(d) provide certain information to regulators in every state in which the Group has members; and

(e) sell only to members of the Group.

The Coalition's COSE Bill takes a conservative approach to Multiple Employer Trusts ("METs") by not proposing to relax the solvency requirements for Multiple Employer Welfare Arrangements in Section 514(b)(6) of ERISA. See generally Buchman, "Insured and Uninsured METs—Current Problems," 16 Connecticut L. Rev. 453 (1984).

We suggest, however, that:

(1) easier means be developed for fully-insured METs to invoke the ERISA preemption included in the current law,

(2) practical impediments to insured and uninsured METs under Section 514(b)(6) of ERISA be reviewed,

(3) alternative means of assuring the solvency of METs be considered, and

(4) related issues in the recent 1989 Operations Report on the Risk Retention Act be reviewed.

6. *Access to Quality Measurement Data.* Groups would specifically be allowed access to the quality measurement data that will be produced under new Federal initiatives. Access to this data will materially assist patients, employees and employers to obtain better quality health care at more affordable costs.

7. *Annual Notice to Employee of Costs.* Employers would notify employees annually in their W-2s or otherwise of the total costs of their Group health insurance, including both the employee and employer paid amounts. Employee access to the total cost of their health insurance will give employees some of the information they need to influence the amount of their compensation that goes to health care, and to help them keep their health insurance affordable.

8. *Self-Employed Premium Deduction.* The self-employed would be allowed the same 100% deduction of health insurance premiums available to corporations.

9. *COBRA and ERISA Reporting.* In order to remove ambiguities in the law, and to encourage the formation of Groups, the Coalition's COSE Bill would (1) make explicit that each employer insured through Groups is responsible for complying with COBRA and ERISA's reporting requirements, and that none of the penalties under those laws apply to a Group; and (2) exempt Groups and employers insured through Groups from pending and future laws that would impose filing fees on ERISA form 5500.

III. CLEVELAND HEALTH QUALITY CHOICE

More fundamentally, a new direction is urgently needed in health care for both the insured and the uninsured. Today the predominant insurance reimbursement system pays for procedures regardless of results and costs. We need to become more efficient and pay for what we do for patients, not for what we do to patients. We must move from a pay-for-service system to a reimbursement system based upon quality, efficiency and results. An example of the new direction that can be taken is Cleveland Health Quality Choice.

Cleveland Health Quality Choice was initiated by ten CEOs of major American organizations—Ameritrust, BP America, General Electric Lighting Group, LTV Steel, Nestle Enterprises, Ohio Bell, Parker Hannifin, Reliance Electric, Sherwin Williams, and Jones, Day, Reavis & Pogue. These ten CEOs are personally stepping forward to make an effort to reform our health care system.

Beginning with this core company involvement, Cleveland Health Quality Choice will grow into a broad, regional initiative based on three principles:

1. *Patient Choice.* Provide employees and patients with a choice in how much of their compensation and income goes to health care. They presently have little choice.

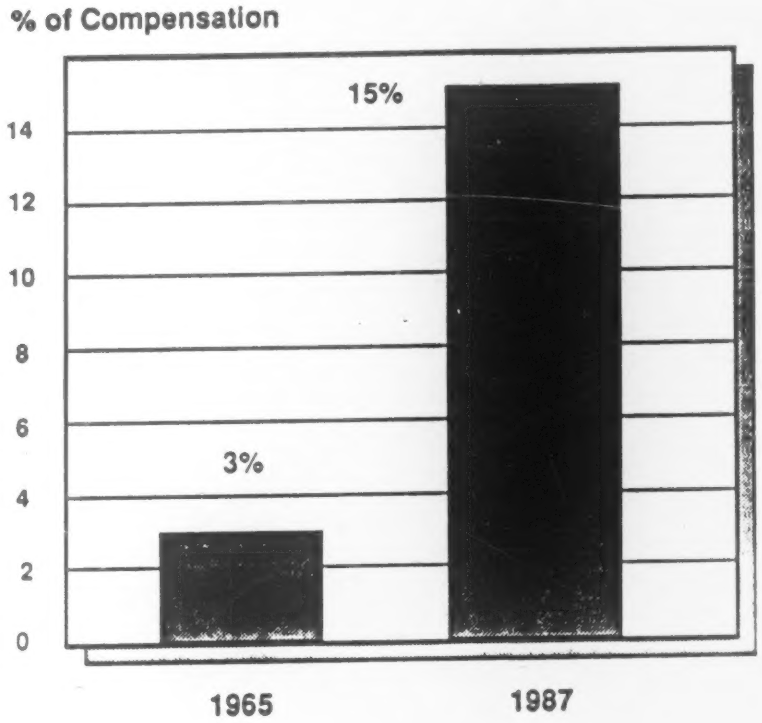
2. *Quality.* Improve the measurement of quality outcomes and provide patients and their doctors with information on quality outcomes and medical uncertainty so that patients receive the best value for their health care dollars.

3. *Incentive Reform.* Change the incentive system for doctors and hospitals so that patient choices on the cost and quality of their health care are rewarded.

Cleveland Health Quality Choice is proceeding on two tracks at the same time. First, employers are implementing, now, health insurance benefit plans that allow employees and their families to choose their health care providers using the best quality/cost information that is available today. Second, to improve the information and feedback process, a community-wide quality/cost measurement system is being developed in cooperation with local employers, hospitals and doctors.

The Health Policy Coalition is willing to work with Congress to develop and implement patient choice alternatives and to pursue the new directions in health care policy we so urgently need. By pursuing new directions, we can preserve health benefits for the more than 200 million Americans that currently have them, and improve access for those that do not.

How Much of an Employee's Compensation Goes to Health Care



Source:
Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

STATEMENT OF STATE REPRESENTATIVE ROMAN KULCHITSKY

Thank you Senator Riegle and members of the Senate Finance Subcommittee on Health for allowing me to give testimony. My name is Roman Kulchitsky. I am the State Representative for the 25th District in Michigan, and I share your concern for the plight of those Michigan citizens who do not have health insurance coverage of any kind—especially children and senior citizens.

In Michigan, the number of uninsured people in 1987 was estimated at 1.05 million. Seventy-five Percent of the uninsured are over the age of 25. Over 30% of the uninsured are employed.

The lack of health insurance has impact on families of Michigan in two important ways. First, families without health insurance risk financial disaster from even one hospitalization. The financial burden of a "catastrophic" health care bill to a family without health insurance can easily overwhelm the assets and income of a middle class family. Senior citizens are especially vulnerable because of "age related" chronic diseases.

Secondly, the "uninsured" are less able to obtain access to medical care to the same degree as insured individuals. This can translate to chronic poor health, especially for those with diabetes, hypertension and chronic respiratory illnesses.

Another confounding problem for expanding health care benefits to the uninsured is the high cost of medical care and its adverse impact on employers' ability to offer health insurance. The U.S. Department of Labor has reported that U.S. employers' health insurance expenditures increased 14.7 percent from September 1988 to September 1989, compar[illegible] a 5.1 percent increase in overall labor costs.

The trend of increa[illegible] health care costs is outstripping the ability of employers to provide health insurance and proving to be a major obstacle in any effort to expand health care coverage to the working "uninsured."

I understand the problems that face Michigan citizens in getting health care, and I would like to propose two private/public partnership initiatives that conceptually are similar to Senator Riegle's proposal.

My first recommendation is to enact legislation establishing a non-profit health insurance pool for small business and tax credits for those businesses who participate.

A central theme regarding Michigan's uninsured is that a considerable number of people without health insurance are employed, yet small or marginally-profitable employers do not offer health benefits. The recommended legislation is designed to make health insurance more affordable for smallbusinesses in Michigan.

Small firms face a number of difficulties in offering health coverage.Often, they simple cannot afford it. They typically pay experience-basedpremiums that can be expensive if an employee is viewed as a bad risk.Because their contracts are so small, their premiums are usually higher thanthose of large employers.

Model legislation, introduced by Representative Gary Randall in the Michigan-State House, would allow small businesses to claim tax credits againstpremiums paid for health benefits (HB 4954), and would create an insurancepool to contract for benefit plans on behalf of businesses and theiremployees (HB 4955).

HB 4954 would allow businesses with fewer than 25 employees to claim asingle business tax credit equal to $25 per month per covered employee or 50percent of the total health insurance premiums paid, whichever is less.

The insurance pool concept spreads the risk among a number of employers andenables small businesses to provide their employees with previouslyunaffordable health coverage.

My second recommendation is that the subcommittee look closely at allowingthe senior citizens, parents of disabled children, and disabled adults whodo not have access to health insurance to buy Medicaid health benefits.

The intent of recommendation is to provide basic health insurance coverageto senior citizens and adults and children who are disabled.

A growing problem for disabled individuals is obtaining health insurance.In general, their disability may be considered by health insurers a pre-existing medical condition which implies to insurers the person is at highrisk for medical claims.

The recommendation allows this group, who find it difficult to obtaininsurance to at least retain the coverage of the state Medicaid program.

The recommendation would offer the opportunity of certain persons who areactively employed by organizations not offering health benefits to buy in tothe Medicaid program. The individual, singly or with disabled dependents,would be given standard eligibility in the Medicaid program in return forpayment of a monthly premium. The proposal would require that the programentirely be funded by employee premiums. Deductibles and co-paymentschedules would need to be drafted by the

Department of Social Services to implement a cost containment "check and balance" on the program.

In closing, I want to thank Senator Riegle and the Subcommittee for this hearing on the growing problem of affordable health insurance coverage for the citizens of Michigan.

Michigan Association of Ambulance Services

The Honorable Donald W. Riegle
United States Senate
SD 105 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Riegle:

Thank you for your invitation to attend the hearing of the Senate Finance Subcommittee on Health.

The Michigan Association of Ambulance Services is a statewide organization representing ambulance and prehospital care providers. We are presenting our views both as health care providers and as primarily small businesses that face the same problems as other small business in providing service.

We are concerned about the effort to expand the Medicaid program because our current reimbursement through the Michigan Medicaid program is not adequate to cover our costs of providing service. We are the only provider that is required by law to provide service regardless of the patient's ability to pay. Thus, Michigan's ambulance providers are caught in a double bind. We are paying to subsidize the Medicaid program as individual taxpayers and as small businesses. Also, we are required to provide additional out-of-pocket dollars each time we transport a Medicaid beneficiary because the level of reimbursement for ambulance service is considerably below the true cost of providing the service. To expand this program without significant improvement in reimbursement to our industry in Michigan would add an increased financial burden where there is already hardship and where many rural areas are unable to afford to maintain the standard of prehospital care that best impacts morbidity and mortality rates.

As small business concerns, we strongly support efforts to assist us in providing comprehensive health care coverage to our employees while being cognizant of the financial feasibility of such efforts.

It is important to note that efforts to control health care costs may best be focused on our industry because early intervention through the provision of quality prehospital care could be the best health care bargain available today. The appropriate management of an airway or immobilization of a fracture in the prehospital setting will frequently prevent expensive long-term care and rehabilitation.

As an Association, we support your efforts in dealing with the very difficult problem of assuring all Americans access to quality health care in the most cost effective manner.

Please contact our office if we can in any way provide you with information, participate on committees, or be of other assistance to you as you work on this difficult issue.

Sincerely,
Brian P. Lovellette

Brian P. Lovellette
Executive Director

Small Business and Health Care
1989 Summary Survey Results

The NFIB Foundation

Charles L. Hall, Temple University
John M. Kudor, Temple University
William J. Dennis, NFIB Foundation

SMALL BUSINESS AND HEALTH

(National Totals)
(n = 5,368)

Do you agree or disagree with each of the following statements? (Mark the appropriate answer.)

		Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	NA	Total
3a.	Americans should receive a minimum level of health care regardless of their ability to pay	18	45	9	17	8	3	100%
3b.	Employees prefer wage increases to increases in health insurance benefits	22	51	10	13	2	2	100%
3c.	The cost of health insurance is a serious business problem	66	26	2	3	7	1	100%
3d.	Health insurance should be one of the first employee benefits that employers provide	12	41	9	26	10	2	100%
3e.	An employee health insurance plan is a good way to get coverage for me/my family	16	50	11	15	6	3	100%
3f.	Taxes should be raised to increase the poor's access to health care	3	10	13	42	26	5	100%
3g.	Employers with employee health insurance pay for employers without it	7	22	25	25	16	5	100%
3h.	Higher paid employees show more interest in health benefits than do lower paid employees	12	42	16	23	5	3	100%
7a.	The cost of employee health insurance can be passed on to customers in the form of higher prices	4	26	6	44	19	2	100%
7b.	Full-time employees show more interest in health benefits than do part-time employees	14	59	13	11	2	1	100%
7c.	Drug/alcohol abuse is a national problem	49	43	3	3	1	1	100%
7d.	Drug/alcohol abuse is a problem for my business	4	16	8	47	22	3	100%
7e.	Government should pay the health insurance premiums of those who can't afford to do so	6	20	19	35	18	3	100%
7f.	There is no real competition among providers of health care services	17	39	14	21	6	2	100%
7g.	Business profitability doesn't let me provide the employee health benefits I would like to provide	27	45	8	16	2	2	100%
7h.	Every American has a right to basic health care	18	51	12	13	5	1	100%
10a.	Government must pay a more direct role in health care to bring health costs under control	24	37	6	22	9	1	100%
10b.	Business can't attract first-rate employees without providing health insurance	14	50	10	23	4	1	100%
10c.	Employees should provide full-time and part-time employees the same benefits	2	7	6	57	27	1	100%
10d.	Health care is becoming prohibitatively expensive	51	40	3	4	1	2	100%
10e.	If an employer does not provide health insurance employees should be required to buy their own coverage	6	24	23	36	10	1	100%
10f.	Potential health insurance costs influence my selection of employees	6	26	23	38	6	2	100%
10g.	AIDS is the nation's most serious public health problem	17	32	20	25	4	2	100%
10h.	Administering an employee health insurance plan is (would be) a nightmare	17	36	17	25	2	3	100%
13a.	I would like to provide better (some) employee health insurance	11	53	13	19	3	1	100%

Do you agree or disagree with each of the following statements? (Mark the appropriate answer.)

		Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	NA	Total
13b.	Prospective employees show lots of interest in health insurance benefits	6	45	18	27	3	1	100%
13c.	Employers should help rehabilitate employees with alcohol or drug problems	3	19	18	42	16	2	100%
13d.	I could earn more working for someone else than in this business	13	28	16	32	8	3	100%
13e.	Health insurance premiums are often wasted because many employees are covered by policies of other family members	9	41	20	26	2	2	100%
13f.	Employee health insurance should be a reward for loyal service, not just granted everyone	14	35	14	32	3	1	100%
13g.	Government interferes in health care too much	15	29	27	24	4	2	100%
13h.	Older employees are more interested in health benefits than are younger employees	15	51	14	16	1	3	100%
15a.	Employers should be required to provide a basic level of employee health insurance	4	20	8	45	22	1	100%
15b.	Most part-time employees do not need the type of benefits full-time employees do	10	44	18	25	3	1	100%
15c.	Employees should pay at least half of the premiums in an employer-sponsored health plan	14	46	18	18	4	1	100%
15d.	My firm has lost good or potentially good employees because of inadequate health benefits	2	9	17	55	17	1	100%
15e.	Insurers compete hard to sell me employee health insurance	7	27	14	40	10	2	100%
15f.	Individuals themselves have first responsibility to see that they have health insurance coverage	29	57	7	5	1	2	100%
15g.	Health insurance costs rise (would rise) payroll costs to the point where it is (would be) difficult to compete	25	48	11	13	1	1	100%
15h.	Employers have a responsibility to provide health insurance	5	20	10	42	22	2	100%

Assuming costs cannot be split or shared, who should pay the health insurance premiums of:

		Person/ family	Person's employer	Government	NA	Total
16a.	a person working full-time whose total family income is about $25,000 a year?	60	27	6	6	100%
16b.	a person working full-time whose total family income is less than $10,000 a year?	35	29	29	7	100%
16c.	an unemployed person?	47	2	42	10	100%
16d.	the children of a person working full-time whose total family income is about $25,000 a year?	71	15	8	6	100%
16e.	a part-time worker whose total family income is less than $10,000 a year?	53	11	28	8	100%
16f.	a teenager, part-time worker, living at home whose total family income is about $25,000 a year?	83	5	6	6	100%

17. If you wanted to increase compensation for your full-time employees by $100 per month, how would you do it?

17a. If you wanted to increase compensation for your part-time employees by $50 per month how would you do it?

	(17) Full-Time	(17a) Part-Time
Provide $/mo. in wages	78	48
Provide $/mo. in health insurance benefits	11	4
Provide $/mo. in benefit(s) other than health insurance	8	3
No part-time employees	—	40
NA	5	4
TOTAL	100%	100%

18. Within the last year, has one or more employees inquired either about instituting a health insurance plan or increasing health insurance benefits under the present plan?

18a. If "yes" how did you handle the inquiries?

	(18)	(18a)
Yes, several inquiries	7	
Yes, a few inquiries	14	
Explained requests weren't currently possible		25
Generally satisfied employee requests		27
Still looking into them		19
NA		29
Total		100%
Casual references, but no inquiries	19	
No inquiries	58	
NA	3	
Total	100%	

14. Does your major competitor(s) provide employee health insurance?

Yes	32
No	20
Don't Know	42
NA	7
Total	100%

19. Do you sponsor a health insurance plan for your employees?

Yes	63
No	34
NA	2
Total	100%

19a. Estimate your cost of employee health insurance as a percent of total wages/salaries paid (Do *not* include any employee contribution.)

1%-2%	8
3%-4%	13
5%-6%	19
7%-8%	18
9%-10%	18
More than 10%	18
NA	6
Total	100%

19b. If "yes", are part-time employees usually (perhaps after a waiting period) eligible to participate in the plan?

Yes	16
No	36
No Part-Time Employees	46
NA	2
Total	100%

19bl. If "no", why do you cover full-time employees, but not part-time employees? (Mark all that apply.)

Insurance more expensive per hour of work for part-timers	29
Part-timers more often want wages than benefits	50
Higher turnover among part-timers	45
Administrative costs/hassle increase enormously	22
Part-timers easier to replace	17
Can't find insurance proportionate to the hours they work	25
Need compensation differences between full and part-timers	25
Can't afford to cover everyone; the first concern has to be my full-time employees	48
Policy doesn't allow part-timers (written)	6
Covered elsewhere (written)	12
Teen-Agers (written)	2
Other	4

		Dependents (19c)	Preexisting Conditions (19d)	Personal Coverage (19e)
19c.	Are dependents of covered employees eligible?			
19d.	Are there employees excluded due to preexisting health conditions or older age?			
19e.	Are you/your family covered under the same plan as the employees?			
	Yes, and a supplemental plan	NA	NA	12
	Yes	83	16	74
	No	13	81	11
	NA	4	3	3
	Total	100%	100%	100%

20.	Why did you institute an employee health insurance plan? (Mark all that apply.)	
	Employees asked for it	25
	Couldn't get/keep good employees without it	31
	Employees needed it	59
	Union negotiated	5
	A tragic event	1
	Good way to cover me/my family	44
	Boost employee morale	45
	Cheaper than a wage increase	8
	Plan in place before I took over	11
	Other	5
	NA	

		15 Percent	30 Percent
21, 22.	Suppose the cost of your health insurance plan rose ___ percent within the next year, what would you do? (Mark all that apply.)		
	Keep the plan I now have	44	22
	Raise deductibles, raise employee share of premium, etc.	53	55
	Lower plan benefits	24	30
	End dependent coverage	5	5
	End part-time coverage	2	2
	Drop the plan	11	29
	NA		
	Total		

23.	If you do not have an employee health insurance Plan, why don't you have one? (Mark all that apply.)	
	Premiums too high	65
	Employee turnover too great	16
	Employees generally covered under a spouse or parent's policy	43
	Administrative expenses too high	17
	Employees prefer cash/Lack of employee interest	34
	Business insufficiently profitable	44
	Profits too unstable from year to year to commit to such a fixed cost	39
	Don't need insurance to attract good employees	23
	Can't qualify for a group policy at group rates	22
	Other (please specify)	

23a.	If you can't qualify for a group policy, what is the reason?	
	Too new in business	5
	Type of business or industry that I'm in	13
	Age of employees I have	4
	Health condition of employees I have	8
	Other ______________	55
	Don't Know	7
	NA	7
	Total	100%

		(24) $150	(25) $100	(26) $60
24, 25, 26.	Suppose the government required all employers to carry a minimum amount of employee health insurance. The cost of the insurance would be about $_____ per employee (full-time and part-time of 20 hours a week or more) per month. If this were to occur, how would you respond?			
	Purchase employee health insurance and adjust elsewhere	42	46	68
	Let all employees go and continue operating	24	24	14
	Get out of your business	26	22	12
	NA	8	9	7
	Total	100%	100%	100%

24a.	If you decided to purchase insurance, how would you be most likely to make the adjustments? (Mark all that apply.)	
	Charge higher prices for my products/services	62
	Eliminate part-time jobs	25
	Eliminate full-time jobs	12
	Reduce hours for some employees	29
	Cut or hold-down other employee benefits	32
	Cut or hold-down employee wage increases	73
	Postpone or cut expenditures for plant/equipment	21
	"Tighten belt" elsewhere	35
	Cut or hold-down earnings	19
	NA	

27.	Are you/your family covered by health insurance?	
	Yes, individual plan	65
	Yes, spouse's policy	20
	No	9
	NA	7
	Total	100%

28.	What would cause you to voluntarily provide health insurance benefits to your full-time employees? (Mark all that apply.)	
	Good employees became more difficult to get	23
	Qualified for a group plan at group rates	27
	Business became more profitable or profits became more stable	55
	Insurance costs fell 20 percent	42
	Fewer teenage and secondary wage-earners in my workforce	5
	Employees asked for coverage	19
	Had less employee turn-over	10
	Had fewer part-time employees	5
	Administrative costs/hassle could be cut	19
	Insurance costs fell 50 percent	52
	Wouldn't provide under almost any circumstances	15
	NA	

1.	What is your form of-business?	
	Proprietorship	30
	Partnership	7
	Sub-S Corp.	15
	Corporation	49
	NA	
	Total	100%

2.	What is your major type of business activity? (If more than one, mark the one that contributes most toward your gross sales.)	
	Construction	15
	Manufacturing and mining	14
	Transportation	3
	Wholesale	8
	Retail	25
	Agriculture	6
	Financial Services	7
	Professional Services	16
	Professions	7
	Total	100%

4.	How many employees do you have, not including yourself? ________ full-time employees ________ part-time employees (= ½ full-time)	
	1-4	39
	5-9	24
	10-19	16
	20-49	13
	50-99	4
	100+	4
	NA	
	Total	100%

5.	Which best describes your employee turnover?	
	High Turnover — (Most employees stay only a few months)	3
	High Turnover — with Stable Core — (Many leave quickly, but a core stay with me)	17
	Moderate Turnover — (Most employees stay a few years)	35
	Little Turnover — (Rarely an employee change)	43
	NA	2
	Total	100%

6. Approximately what percentage of your full-time employees are "heads-of-household," i.e., the family's primary bread winner?

None	11
1-25%	14
26-50%	13
51-75%	20
76-100%	39
NA	3
Total	100%

---

8. During the last calendar or fiscal year, what were your gross receipts?

Under $100,000	10
$100,000-199,999	16
$200,000-349,999	17
$350,000-749,000	19
$750,000-1,499,999	15
$1,500,000-2,999,999	10
$3 Million and Over	11
NA	2
Total	100%

---

9. Which best describes your annual gross sales over the last two years?

Declined (More than 10%)	9
Declined a Bit (5-10%)	13
Stayed the Same	26
Grew (5-25%)	42
Grew Rapidly (26%)	7
Too New	2
NA	1
Total	100%

---

11. How long have you owned/operated this business?

1 Year	2
2-3 Years	9
4-5 Years	10
6-9 Years	14
10-19 Years	31
20 +	32
NA	2
Total	100%

---

12. Which best describes the area in which your business is located?

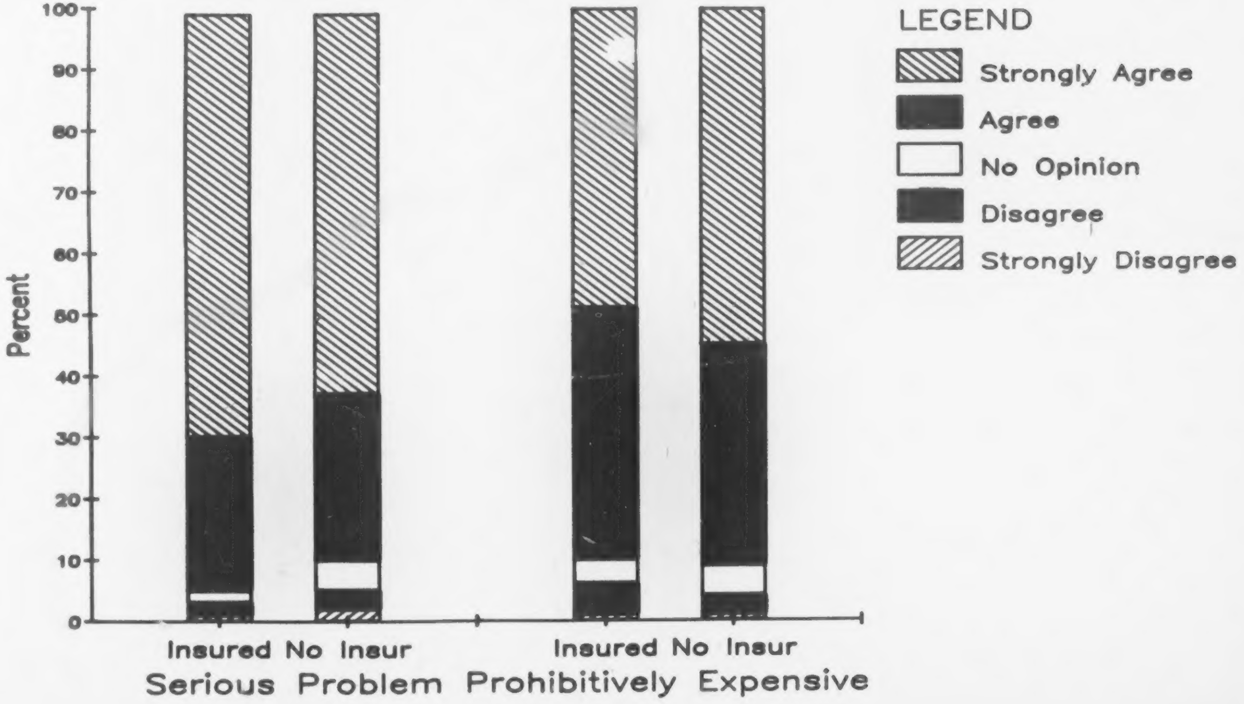
Rural area	30
Small city or large city suburb	51
Large city	15
NA	4
Total	100%

---

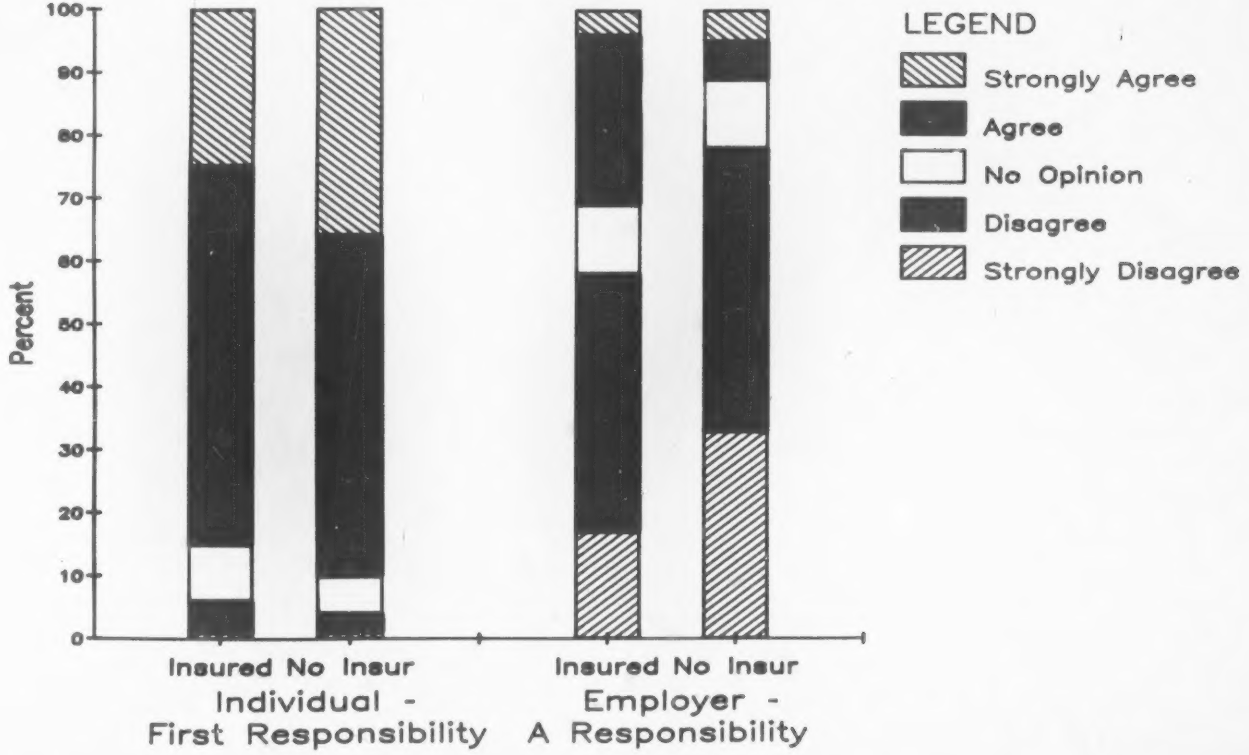
29. About how much did you take out (salary, draw, earnings, etc.) of the business last year?

Prefer Not to Answer	19
Under $10,000	10
$10,000-19,999	12
$20,000-29,999	16
$30,000-39,999	10
$40,000-49,999	9
$50,000-59,999	5
$60,000-69,999	3
$70,000 or more	11
NA	5
Total	100%

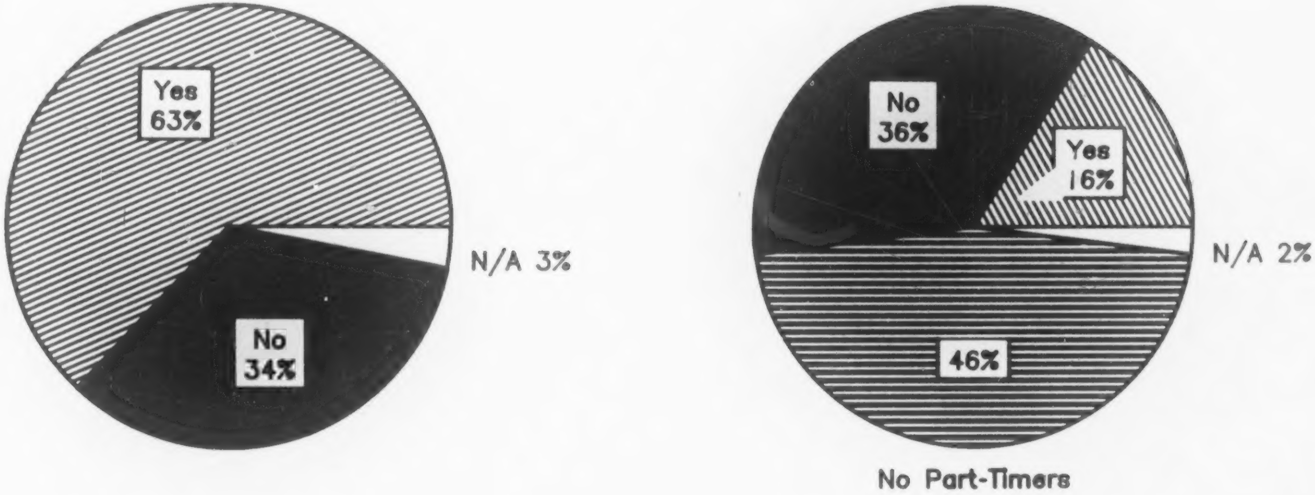
HEALTH INSURANCE COSTS A SERIOUS BUSINESS PROBLEM AND HEALTH CARE BECOMING PROHIBITIVELY EXPENSIVE - SMALL EMPLOYERS' VIEWS



RESPONSIBILITY FOR PROVISION OF EMPLOYEE HEALTH INSURANCE - SMALL EMPLOYERS' VIEWS



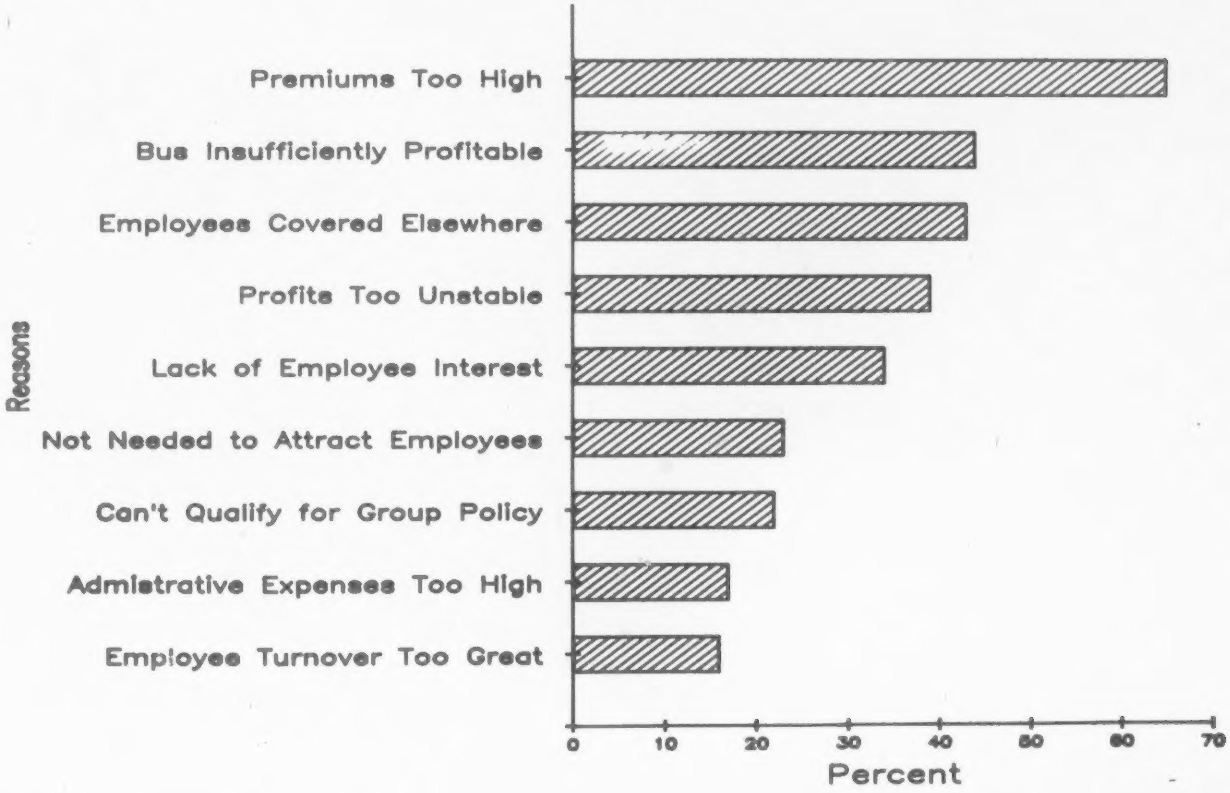
SMALL BUSINESSES PROVIDING AND NOT PROVIDING EMPLOYEE HEALTH INSURANCE



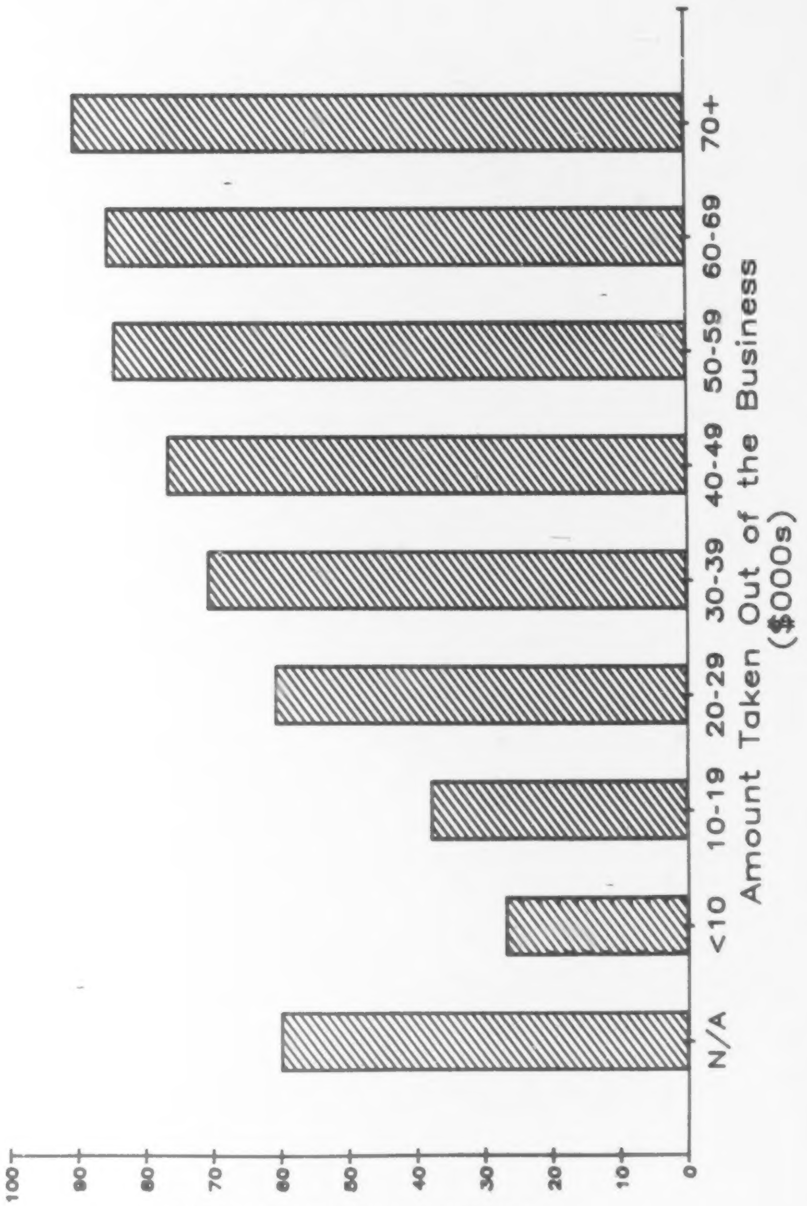
Any or All Employees

Part-Time Employees Only

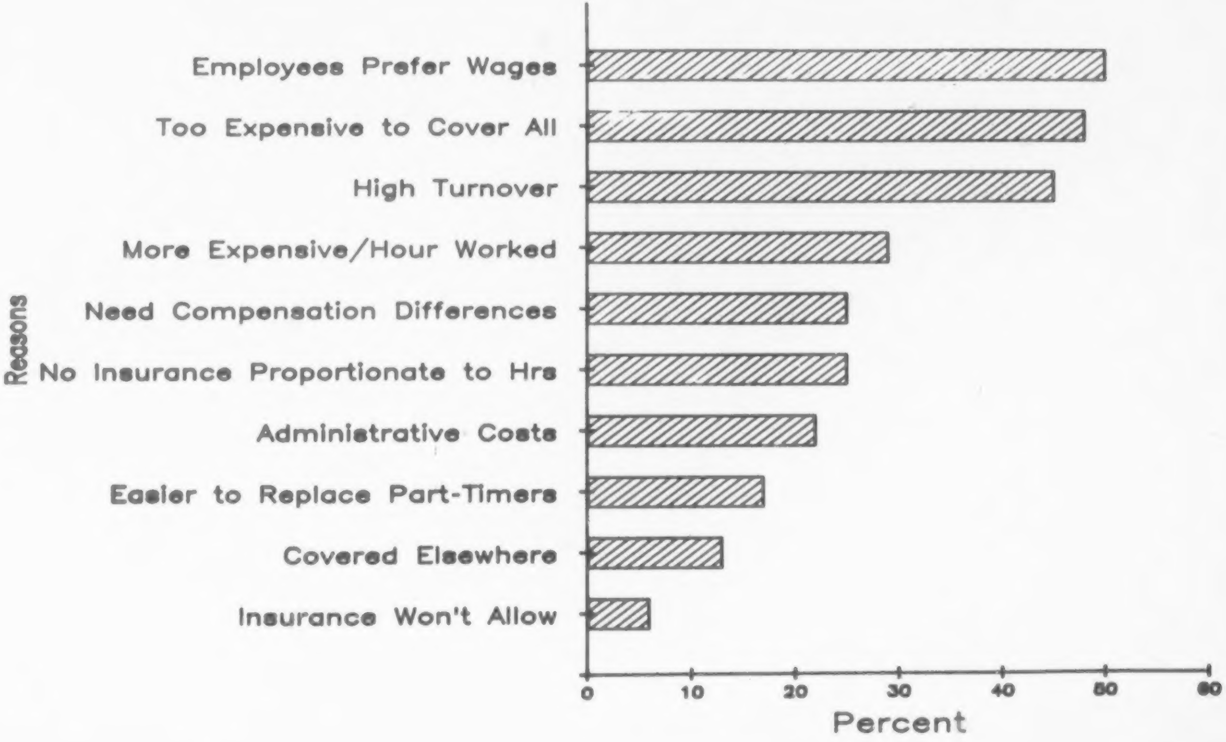
SMALL BUSINESS OWNER REASONS FOR NOT PROVIDING EMPLOYEE HEALTH INSURANCE



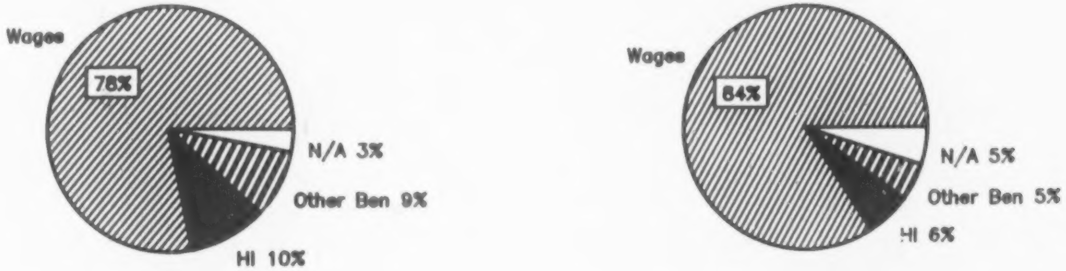
FIRMS WITH EMPLOYEE HEALTH INSURANCE COVERAGE BY OWNER'S "TAKE-OUT"



REASONS FOR NOT COVERING PART-TIME EMPLOYEES IN BUSINESSES WITH EMPLOYEE HEALTH INSURANCE

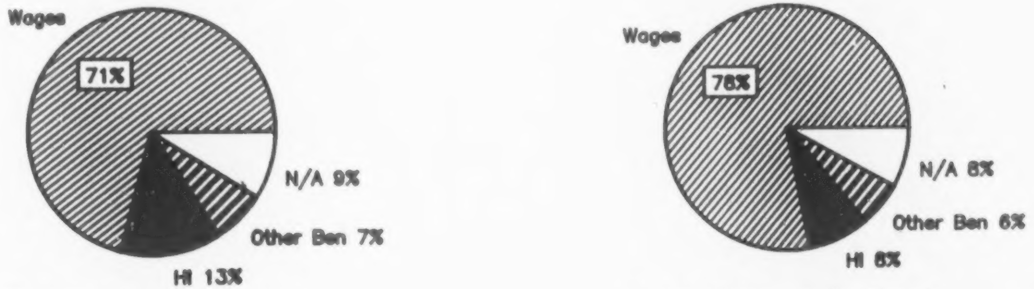


METHOD OF ALLOCATING AN ADDITIONAL $100/MO (FULL-TIME EMPLOYEE) OR $50/MO (PART-TIME EMPLOYEE) BY POSSESSION OF EMPLOYEE HEALTH INSURANCE



Full-Time, with Insur

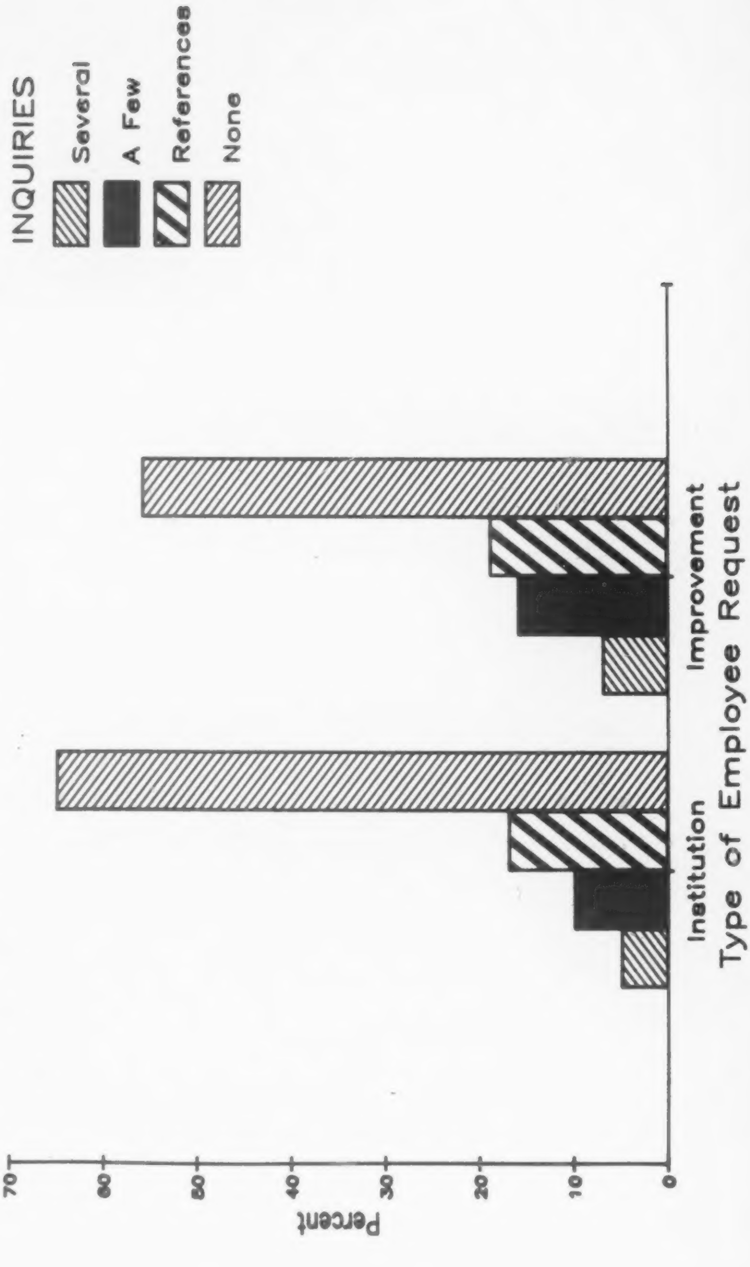
Part-Time, with Insur



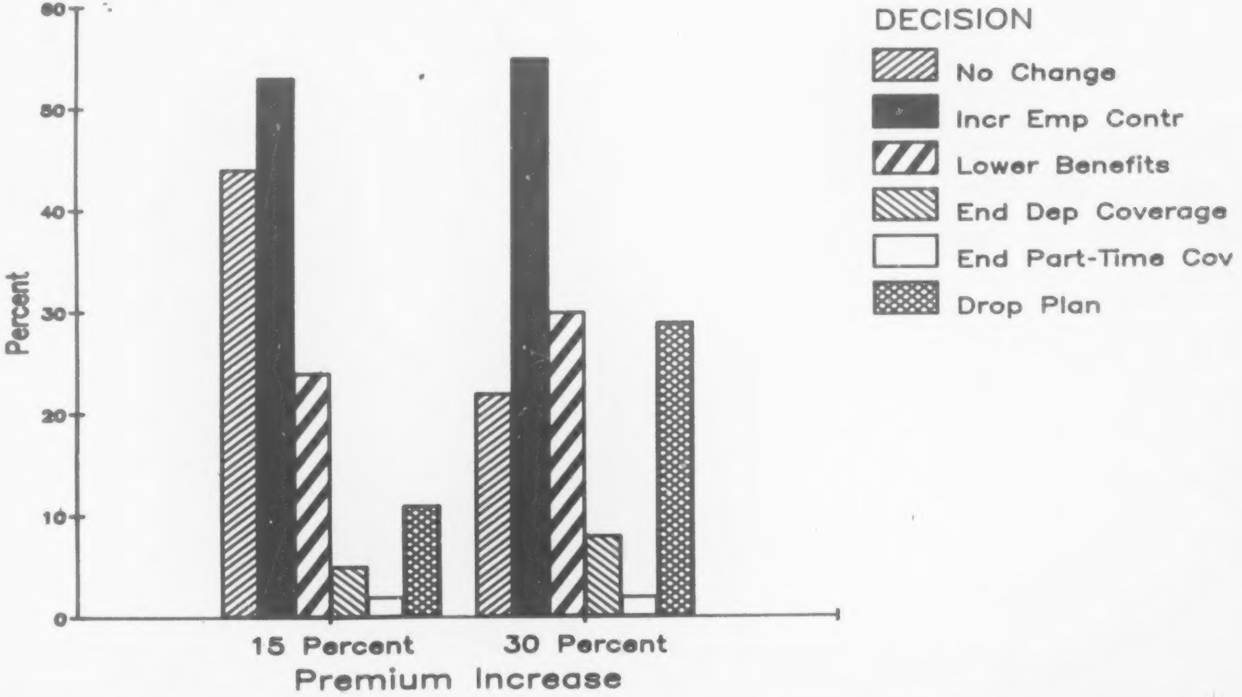
Full-Time, w/o Insur

Part-Time, w/o Insur

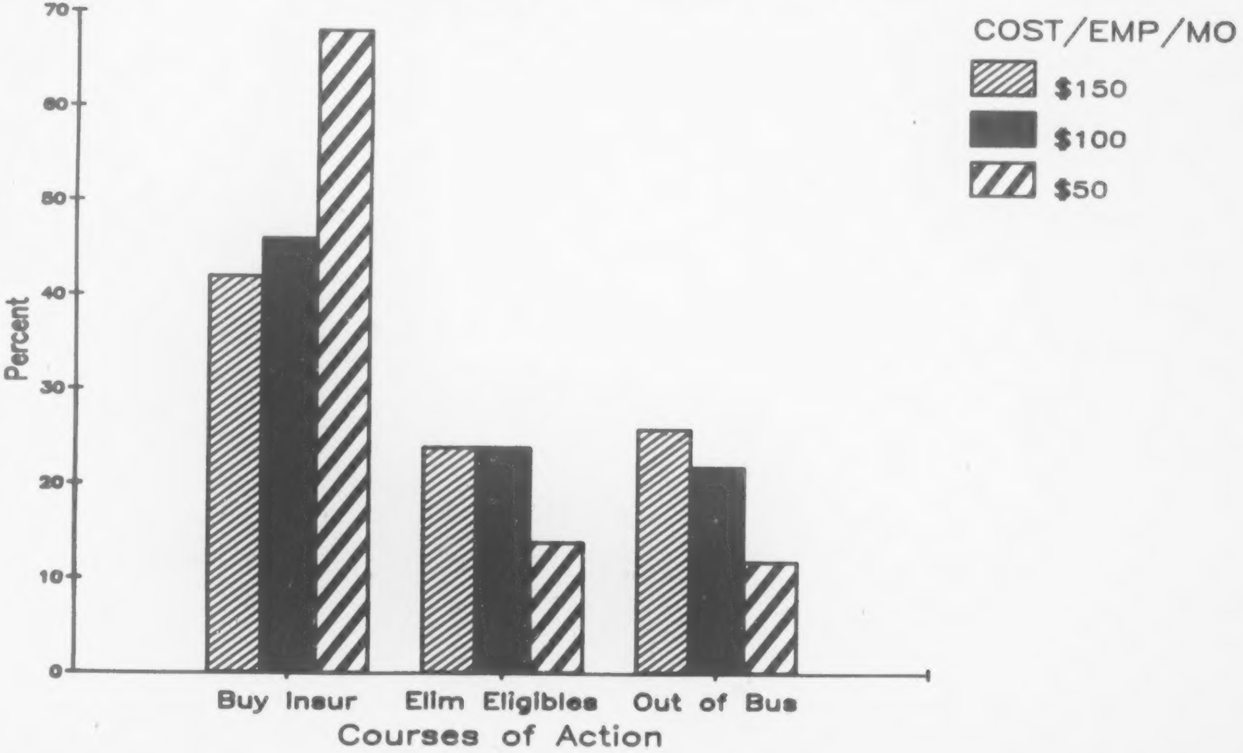
EMPLOYEE INQUIRIES IN THE LAST YEAR ABOUT INSTITUTION OR IMPROVEMENT OF AN EMPLOYEE HEALTH INSURANCE PLAN



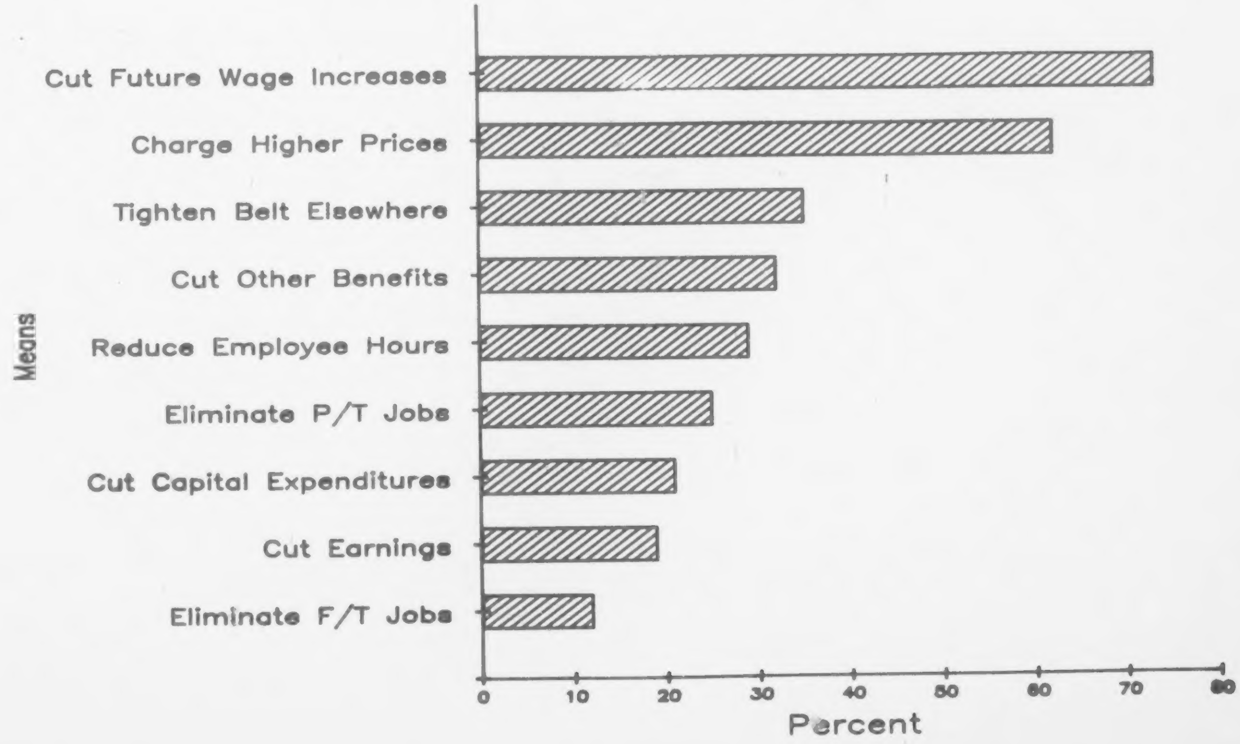
IMPACT OF A 15 PERCENT AND A 30 PERCENT INCREASE IN EMPLOYEE HEALTH INSURANCE PREMIUMS ON DECISIONS AFFECTING CONTINUATION OF THE SAME PLAN



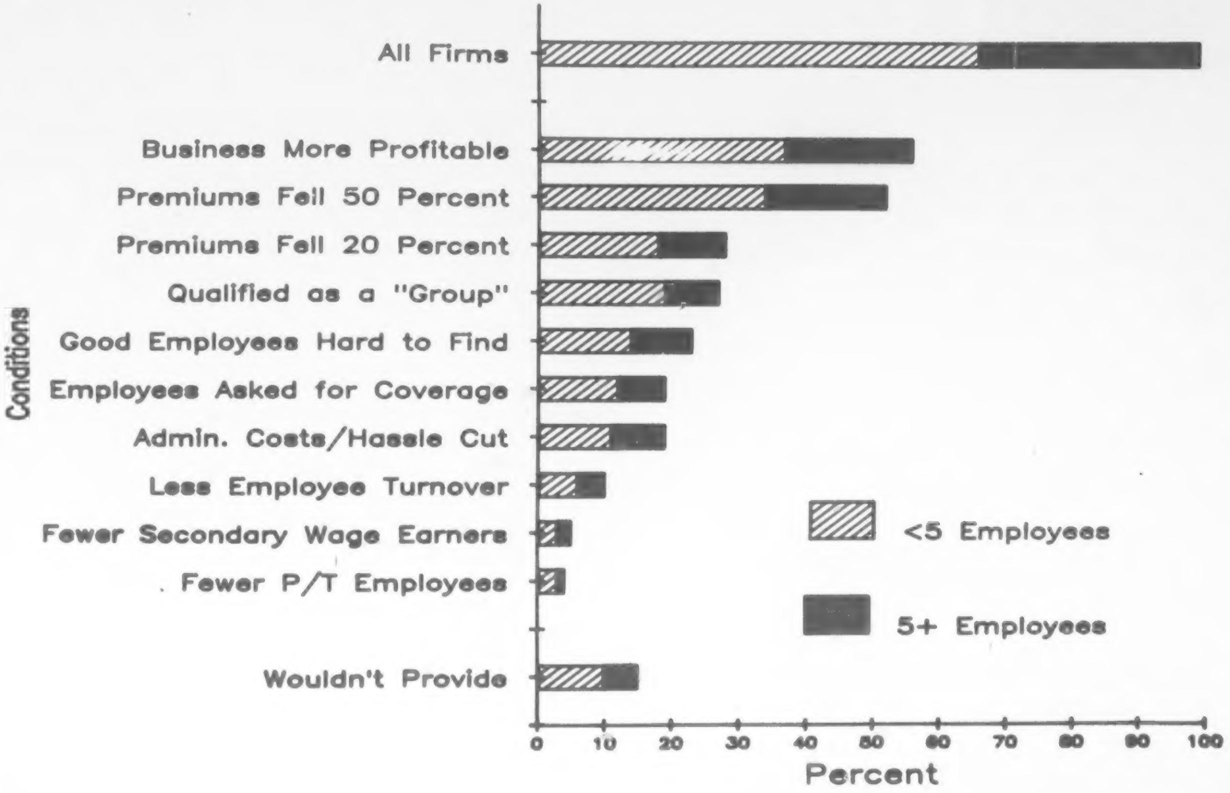
IMPACT OF SELECTED MANDATORY COVERAGE COSTS ON SMALL FIRMS WITHOUT EMPLOYEE HEALTH INSURANCE



MEANS TO COMPENSATE IF EMPLOYEE HEALTH INSURANCE EQUAL TO $150/EMPLOYEE/MONTH



CONDITIONS REQUIRED FOR VOLUNTARY PURCHASE OF EMPLOYEE HEALTH INSURANCE



MACOMB COUNTY COMMUNITY SERVICES AGENCY,
Mount Clemens, Michigan, February 13, 1990.

Hon. DONALD W. RIEGLE, JR.,
1850 McNamara Bldg.,
477 Michigan Ave.,
Detroit, MI

Dear Senator Riegle: Macomb County Community Services Agency is the Community Action Agency for Macomb County. Our mission is to advocate for the poor, handicapped, and elderly of our communities.

In response to your request for public comment on Health Care for all Americans I would like to submit the following:

One of the programs MCCSA operates is the distribution of Food Stamps. During January 1990, 10,519 individuals picked up food stamps. The majority of those families receiving food stamps are working. These people do not have health care benefits. Needless to say families do not practice preventative health care and often will not seek care until it is an emergency. The end result is that we" all pay and costs are higher because the family denied themselves care until it became a crisis.

I believe that a combination of the plans you are proposing would alleviate the problem. Every American should have access to a basic health care package. Run away costs and profits have seriously harmed the entire system.

I also believe costs could be controlled for business if a family unit could be covered only under one health care plan. Even though the County offers an incentive for employees with other health coverage to not participate in the County program people still feel they are somehow short-changed if they do not.

On behalf of the vulnerable in Macomb County, I hope that the voices expressed through Community Action Agencies will be heard and that basic health care will become a reality for all citizens.

Please do not hesitate to contact me if additional information or statistics are desired.

Thank you for the opportunity to voice these concerns and please let me know how I may assist you with this endeavor.

Sincerely,

PATRICIA A. GIBBS, *Executive Director.*

OFFICE OF HEALTH & COMMUNITY SERVICES, WAYNE COUNTY,
Detroit, MI, February 1, 1990.

Senator DONALD W. RIEGLE, JR.,
1850 McNamara Federal Building,
477 Michigan Avenue,
Detroit, MI

Dear Senator Riegle: We in Wayne County applaud your efforts in addressing the problem of lack of health insurance for a growing percentage of our population, and I would like to submit an update on our efforts as written testimony for the public record.

As you know, the CountyCare program provides a comprehensive range of health care benefits to approximately 50,000 General Assistance recipients in Wayne County. This program has reduced costs for indigent care in Wayne County without sacrificing the quality of care delivered to enrollees. We believe, in fact, that the quality of such care has been improved since Countycare's implementation on October 1, 1988.

Building on CountyCare's success, County Executive McNamara has initiated planning for a program to address the growing problem of lack of health insurance for employed individuals. This program, called HealthNet, is envisioned to provide a broad range of services to employees through agreements with their respective employers.

Both CountyCare and HealthNet take a managed care, or HMO, approach by providing a capitated payment to providers based on the number of enrollees, irrespective of the number of services any individual enrollee receives. Furthermore, both programs represent an innovative public/private partnership designed to address the concomitant problems of indigent health care and health care for uninsured workers.

I look forward to hearing your approach to these issues at the February 15th Senate Finance Subcommittee on Health hearing in Warren.

Sincerely,

Vernice Davis-Anthony, *Assistant Wayne County Executive.*

COUNTYCARE ANNUAL REPORT 1988–1989

WHAT IS COUNTYCARE

CountyCare is the name of the Wayne County Michigan health, hospitalization and general assistance medical program. The program is under the management of the Wayne County Office of Health and Community Services, and is administered by the Wayne County Patient Care Management System (PCMS).

CountyCare takes a managed health care approach, serving the Wayne County General Assistance (GA) population, and covers a comprehensive range of outpatient, inpatient and home health care services previously inaccessible to this population.

Effective management of patient care utilizing a managed care, HMO style approach involves the selection, combination and sequencing of medical care to offer the greatest expectations of promoting patients' health at the least cost, thereby producing a financial incentive for the health care providers. This strategy requires the provision of the highest quality care possible in a given situation. The incentive to the provider is to provide primary and preventive health care, as well as preventive programs such as health care classes.

MISSION STATEMENT

The Wayne County CountyCare program provides a comprehensive range of health care services to approximately 50,000 General Assistance (GA) recipients residing in Wayne County. These recipients are enrolled in one of four accessible, quality health care system networks on a sound, cost-effective basis.

THE MANAGED CARE HMO APPROACH

The four health care providers have been contracted to provide health care services at a capitated payment rate per member month, whether or not the client receives treatment.

As a result, health care providers should be able to realize a profit due to the use of a managed care HMO approach of improved access, utilization control, cost containment and quality assurance, thereby operating under the annual budget.

LEGISLATIVE HISTORY

Public Act 216, passed in 1979, modified the Public Welfare Act of 1939 (P.A. 280) by including provisions which allowed the Michigan Department of Social Services to serve as fiscal intermediary between hospitals and Wayne County under the County's Resident County Hospitalization (RCH) program. This legislation also provided that such payment levels be consistent with the Medicaid program, and that the State could collect from each County the amount which the County would have paid hospitals prior to the effective date of P.A. 216.

The effect of this act was that the State payment to hospitals grew completely unchecked, since neither prior County knowledge nor approval of payment amounts was possible under the provisions of P.A. 216. The State then billed Wayne County for the amounts which the State had paid to hospitals, often up to two (2) years later. By 1982, Wayne County was spending an amount equivalent to 30% of its total property taxes on the RCH program and, since the County revenues could not finance such an amount, the payback obligation to the State approached a crisis phase.

The Michigan Department of Social Services Appropriations Act of 1982 allowed for the creation of the Wayne County Patient Care Management System. Between 1982 and 1985, PCMS was able to hold the increase in RCH costs to less than 15%, whereas the same costs rose by over 25% for other private and public hospital programs. Even so, the continued increase in such costs only exacerbated Wayne County's fiscal crisis attributable in large part to its costs of providing hospital care to the indigent population.

In December of 1987, Enrolled House Bill 4452 (P.A. 266) was enacted which gave Wayne County the authority to combine, under County administration through its Patient Care Management System, the RCH program with the State's General Assistance Medical outpatient program. Between December of 1987 and Countycare's implementation on October 1, 1988 PCMS tripled the number of staff and completely developed and implemented the managed health care system for General Assistance recipients known as CountyCare.

PCMS DIVISIONS AND FUNCTIONS

Finance/Management Information Division

This division has primary responsibility for facilitating and monitoring the flow of funds and data to and from the program. This includes ensuring timely payment from CountyCare funding sources, namely the State of Michigan and Wayne County, as well as payment to program contractors each month based on their respective enrollments.

Integral to this process is receipt of monthly enrollment data from the State of Michigan which is then processed to determine each contractor's proper enrollment and capitation payment. This division also receives and processes utilization and other data from program contractors, as well as participating in various contract negotiations germane to its functional responsibilities.

Legal Division

The Legal division provides legal counsel to PCMS, and assumes a lead role in preparation, and negotiations, of a variety of contracts, most notably those with the four medical care contractors. Additions, changes, deletions and addenda to any contracts are, of course, also a primary responsibility for this division. Related to this function is the monitoring of pending and enacted legislation which may have bearing on CountyCare.

Developing the policies and procedures for CountyCare's patient and provider conflict resolution processes has been an area of keen focus. It is CountyCare policy that each contractor have in place a conflict resolution process within their respective system to address concerns of either patients or other providers. To date, this has proved extremely successful thereby eliminating the need for any formal appeals to be filed with PCMS.

Provider Relations Division

The Provider Relations division's primary function is to track the various contracts through the County's intricate contract approval process once the legal division, the Patient Care Management System Director and the Assistant County Executive for Health and Community Services have successfully concluded negotiations.

Additional areas of responsibility include acting as primary liaison with the contractors in daily operations, representing PCMS to various local agencies, ensuring contract compliance, and monitoring the requests of enrollees wishing to change their assigned contractor.

Quality Assurance Division

The Quality Assurance division has developed and conducts an ongoing quality assurance program to monitor and evaluate the quality and appropriateness of health care services received by CountyCare enrollees. This division also provides direct and immediate intervention as valid problems directly related to medical care are presented to its nurses by either providers or patients.

Within this division is a program wide Quality Assurance Committee consisting of quality assurance specialists from PCMS and each of the four contractors, and chaired by PCMS' Medical Director. This committee conducts more focused activity, such as analysis of diagnosis-specific quality of care and development of quality of care standards, as well as addressing quality assurance concerns of a more general nature.

RELATED FUNCTIONS

PCMS Medical Director

The Patient Care Management System's Medical Director chairs the CountyCare Quality Assurance Committee and also reviews incoming appeals to determine the medical facts associated with the case.

PCMS Dental Consultant

CountyCare incorporated the State administered General Assistance Dental program into its capitated program structure, effective October 1, 1989. In planning for this transition, PCMS has worked with a practicing dentist familiar with the needs of the covered population to ensure a smooth transition.

Wayne county Citizens Advisory Group on Indigent Care

Although not part of PCMS, this advisory group receives technical support and periodic updates from the CountyCare program.

Quality Assurance Reviews

As part of CountyCare's ongoing quality assurance activities, three independent organizations were contracted with to conduct separate reviews of three components of the CountyCare program.

The three organizations and their respective areas for review are:

(1) Joint Commission on Accreditation of Healthcare Organizations:

The Joint Commission reviewed the administrative structure and functions of each of the four contracting organizations during the summer of 1989. Although initial general findings were shared with each contractor at the time of their review, complete results will be shared with PCMS Administration and CountyCare providers early in 1990.

(2) Innovative Health Care Management Inc:

This organization will be conducting a review of randomly selected ambulatory encounters to determine consistency with community standards for the delivery of ambulatory health services.

(3) Michigan Peer Review Organization (MPRO):

MPRO will be conducting a review of inpatient hospitalizations to ensure consistency with standards commonly used for other programs, such as Medicaid. This will also be a random sample.

DESCRIPTION

Shortly after CountyCare's implementation, the Wayne County Commission established an independent Citizens Advisory Group For Indigent Care. This group's primary function is to independently monitor the access to, and quality of, health care services for indigent populations within Wayne County.

While the CountyCare enrollment constitutes a large portion of this population, it is by no means the entire population. A much larger number of Wayne County residents than those covered under CountyCare continue to lack any public or private health care insurance. It should be noted that the formation of CountyCare was never intended to solve the problem of all the uninsured in Wayne County. This is a problem which many agencies and entities are grappling with, including Wayne County, Governor Blanchard's Task Force on Access To Health Care, and many other local and state agencies and organizations.

The Citizens Advisory Group's composition reflects broad representation from community groups, health care providers, the clergy and the business community. This group coordinates its efforts with the Governor's Task Force, The Greater Detroit Area Health Council, the Michigan Association for Local Public Health and other responsible entities.

COUNTYCARE ELIGIBILITY CRITERIA

Those persons residing in Wayne County who are determined by the State of Michigan Department of Social Services as eligible for the State's General Assistance Cash Program are eligible for the CountyCare Program.

These are low-income residents who have no other public or private insurance coverage, and meet the — other program eligibility criteria. Individual eligibility for the General Assistance program, and therefore CountyCare eligibility, is determined on a monthly basis.

The General Assistance criteria at the time of application are as follows:

- Age 21 through 64, inclusive
- Wayne County residency
- Income or cash assets of $250 or less
- Ineligible for Medicaid, Medicare or other third party insurance.

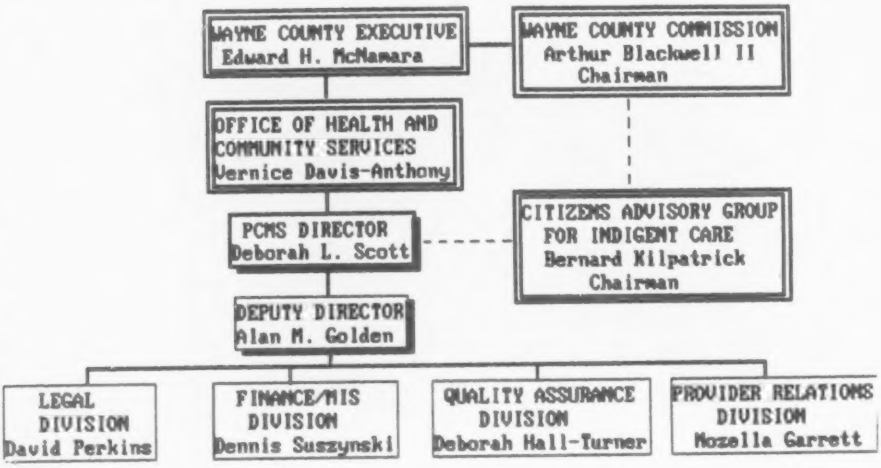
Those individuals not meeting all the above criteria, including those who *may* meet the criteria but have not yet applied and been *approved* for General Assistance, are not eligible for CountyCare. COUNTYCARE ENROLLEE DEMOGRAPHIC PROFILE

The demographic profile of the CountyCare population by race, age and gender is as follows:

- Race distribution
  - —Black 90%
  - —Non-Black 10%
- Age distribution
  - —21-34 38%
  - —35-44 28% [Average Age: 40]
  - —45-64 34%
- Gender distribution
  - —Male 60%
  - —Female 40%

COUNTYCARE ANNUAL REPORT
1988-1989

WAYNE COUNTY PATIENT CARE MANAGEMENT SYSTEM ORGANIZATION CHART


WAYNE COUNTY EXECUTIVE
Edward H. McNamara
WAYNE COUNTY COMMISSION
Arthur Blackwell II
Chairman
OFFICE OF HEALTH AND COMMUNITY SERVICES
Vernice Davis-Anthony
PCMS DIRECTOR
Deborah L. Scott
CITIZENS ADVISORY GROUP FOR INDIGENT CARE
Bernard Kilpatrick
Chairman
DEPUTY DIRECTOR
Alan M. Golden
LEGAL DIVISION
David Perkins
FINANCE/MIS DIVISION
Dennis Suszynski
QUALITY ASSURANCE DIVISION
Deborah Hall-Turner
PROVIDER RELATIONS DIVISION
Mozella Garrett

COUNTYCARE ANNUAL REPORT
1988-1989

COUNTYCARE PROVIDER NETWORK OF DELIVERY SITES

CONTRACTOR	PRIMARY CARE	HOSPITAL	VISION	AMBULANCE	HOME HEALTH	PHARMACY	HEARING	
SOUTHWEST DETROIT HOSPITAL	3 sites	7 sites	2 sites	3 Prvdrs	3 Prvdrs	5 sites	1 sites	
MICHIGAN HEALTH-CARE CORP.	20 sites	3 sites	11 sites	2 Prvdrs	1 Prvdrs	9 sites	2 sites	
UNITED AMERICAN HEALTH-CARE CORP.	6 sites	4 sites	9 sites	1 Prvdrs	2 Prvdrs	21 sites	2 sites	
HEALTH-SOURCE	6 sites	6 sites	11 sites	2 Prvdrs	3 Prvdrs	32 sites	5 sites	**Total Sites**
Total	35 sites	20 sites	33 sites	8 Prvdrs	9 Prvdrs	67 sites	10 sites	**182**
COUNTYCARE DENTAL INC.	Multiple sites throughout County							

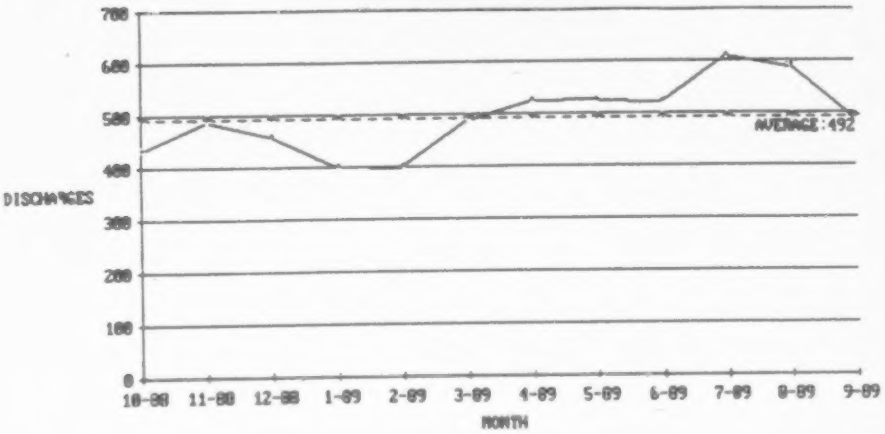
Rev. 9/20/89
MJO/dlc dwdoc/89a106

COUNTYCARE ANNUAL REPORT
1988-1989

UTILIZATION STATISTICS

o CountyCare Inpatient Hospital Discharges

TOTAL COUNTYCARE DISCHARGES BY MONTH
OCTOBER 1988 - SEPTEMBER 1989



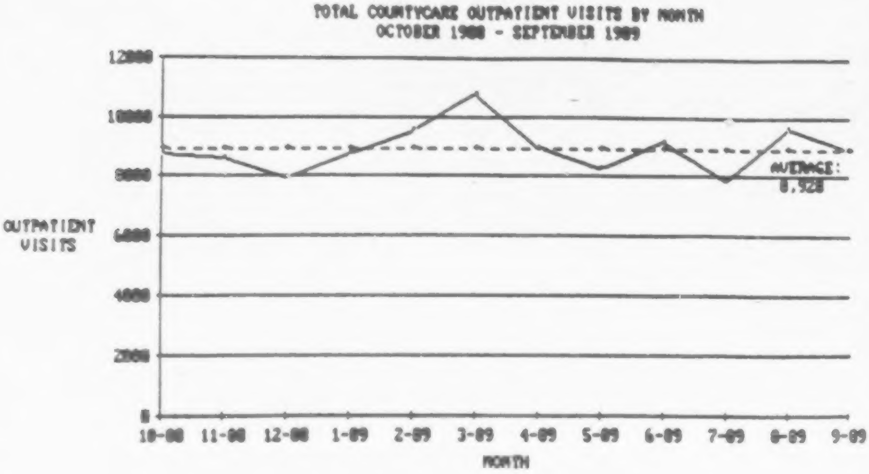
COUNTYCARE DISCHARGES BY MONTH

Oct 1988	432	Apr	522
Nov	486	May	524
Dec	457	Jun	520
Jan 1989	400	Jul	608
Feb	398	Aug	588
Mar	486	Sep	486

Average: 492

COUNTYCARE ANNUAL REPORT
1988-1989

o CountyCare Outpatient Visits



COUNTYCARE OUTPATIENT VISITS BY MONTH

Oct 1988	8,757	Apr	8,952
Nov	8,622	May	8,231
Dec	7,947	Jun	9,162
Jan 1989	8,755	Jul	7,859
Feb	9,540	Aug	9,628
Mar	10,793	Sep	8,891

Average: 8,928

RESPONSES TO A RQUEST BY SENATOR RIEGLE FOR COMMENTS

Date; ____________

TO WHOM IT MAY CONCERN;

Dear ____________________,

Enclosed are some documents that I hope will support what is the reason for this letter. I can only wonder how many other people have found themselves in the situation that I have now.

I am almost 60 years old, and my job opportunities are somewhat limited in our present economy. However, after not being hired back at Jordan College, I was faced with unemployment. I elgible for Social Services which included GA (HMO?) for my personal health. I have not worked for anyone that I was able to receive Medical or Dental coverage since 1977. The jobs got me by alright, but there was NO benefits involved.

When I was informed by my Case Worker that I had such benefits, I was really excited, because my teeth had been infected for several months and my physical condition was deteriorating fast. I really looked forward to feeling well again, but as things began to develope, it became clear that this was not hapening! You can only imagine the frustration and anxiety of one thing after another that caused the deterioration from this direction!

When I asked for Doctors and Dentists that I could attend, I was given several, but only the Doctors involved accepted GA Medical.

I hope these papers can aid you in helping us get a fair process!!!

PS. Special thanks to;

Trini, RECIPIANT UNIT, MEDICAID PROGRAM
P.O. BOX 30037
LANSING, MI 48909

AND Ms. Cathy Merriman, STATE of MICH.
DEPT of SOCIAL SERVICES
FLINT, MI 48507

Respectfully,

Robert L Bensinger

Robert L. Bensinger
11344 W. Carpenter Rd.
Flushing, MI 48433
Phone; (313) 659-2028

21 February, 1990

U.S. Senator Donald W. Riegle Jr.
352 S. Saginaw   Suite 910
Flint, MI 48502

Dear Senator Riegle,

In the February 16 edition of the Flint Journal, I was greatly impressed by the hearing on health insurance. I'm thankful, that, someone finally is taking a look at this much abused area. For several years, I had taught State and Local Government at Jordan College. I was amazed at the difficulties that the students were having with various services from the city and state. Until I was actually involved by unemployment, I could not imagine the scope or depth of these people's problems. I can believe, now, what they said.

I'm really concerned for the quality of personnel that are directly in contact with clients on medical or dental services. If THEY don't process the intake properly, their BILLING Agents can "come in on their clients" with all kinds of collections threats! In addition, there are so many "cross-related" agencies on the way to "the top", that clients are "stone walled" before they ever get started!

Senator Riegle, I'm enclosing copies of documents that I've received from various agencies and my responses to them. I apologize for the complex nature of my presentation of these forms, but I'll try to keep some order for you. Going by dates might be effective.

I am at your service at any time to explain any part of this on your request. I can also keep you up to date on pending events.

Respectfully,

Robert L Bensinger

Robert L. Bensinger
11344 W. Carpenter Rd.
Flushing, MI 48433

Phone; (313) 659-2028

MEDICAL and DENTAL PROBLEMS EXPERIENCED

DATA; Robert L. Pensinger, 11344 W. Carpenter Rd., Flushing, MI 48433
SS# 371-28-1608 BIRTH; 5-15-30
GA MEDICAL Effective; 5-25-89 to 10-14-89.
UNEMPLOYMENT Began; 10-14-89 to 3-?-90.
CASE WORKERS; Ms. Moynihan (initial) (313) 768-2025
Ms. Howd (present) ? (313) 768-2397
Flint Department of Social Services

I. MEDICAL SITUATIONS;

Doctor Referred; Dr. Edward Conley (15-9-89)
G-3273-A Beecher Rd.
Flint, MI 48532 (313) 230-8677

A. Went to Dr. Conley for fever, nausea, flu-symptoms,lower back pains, dizziness and loss of balance. Diarrhea complications set in!

B. Loss of feeling in arms-fingers, and lower legs-feet. Pain in toes.

C. Blood tested twice, and stool sample once. Nothing was found except blood-acid count was high. This was not found until 2nd test.

D. Sent to a Doctor for shock treatments.Why?

E. Sent to Radiology lab, three times, for x-rays.

F. Blood pressure taken on both legs. Arteries were said to be very good, but veins were not. Nothing was done in follow-up.

G. Scheduled to go to a Dr. McIntosh for arthritic exams . I didn't go because my Medicaid was stopped.

H. Given shots for pains in lower back. Temporary relief only.

I'm sure there may have been more, however, the above will be adequite.

II. SUMMARY;

A. I was told that I have "degenerative arthritis" by Dr. Conley.

B. All the Doctors(?) I was sent to were D.O.s.

C. I never was told what the shock treatments were supposed to find.

D. Blood tests did not show the amount of poison that my infected teeth were causing, nor did the high acid count in my blood made aware until, I had asked specifically to know. No Urinalysis test or abdominal check .

III. CONCLUSIONS;

A. I still have the same symptoms as I first began seeing Dr. Conley.

B. My hands and feet were never X-rayed.

C. I really feel that all this has been an extreme waste of time and money!

D. I feel heavy abdominal pressure and urinal problems that are increasing.
NOW, I can't get proper medical treatment, and everythings getting worse!

PART II DENTAL

I. DENTAL SITUATIONS;

Doctor Selected; Thomas A. Smiggen, Owosso, MI.

DOCTOR REFERRED; Irving S. Bernstein, Clio, MI.

A. There was two weeks delay on each set of X-rays taken.

B. Dr. Bernstein only worked on Mondays, thus limiting appointments.

C. Appointments ranged from 5 minutes to 1 hour. Most, however, were less than 25 minutes. B and C shows a large amount of time misused.

D. X-rays showed that upper teeth (6) were very infected and needed to be extracted. X-rays didn't show that the bottom teeth needed to be extracted, however, now these teeth are going the same way as the others.

E. In deadening the upper teeth for extraction, Dr. Bernstein pushed the needle so far up, that extreme swelling occurred near the nose.

F. Dr. Bernstein used very poor sanitary precautions during this time.

G. After extracting these teeth, large bone fragments were left that should have been "cleaned up" at this time. Almost a month later, my gums had to be cut up again to dig out these fragments. Not only was this painful but it caused MORE delay in getting my dentures.

H. My bottom teeth (7) were to be cleaned also (Dr. Bernstein said), however, ONLY the end teeth were cleaned where the lower partial would be attached during wear. My bottom teeth didn't get any care at all.

I. Dr. Bernstein told me to go to the local Pharmacy for pain pills and told me I was covered by Medicaid. I had to pay this bill myself!!!

J. I had 4 impressions made for the upper denture and 3 for the partial. Is this the appropriate number? It seemed that there was something wrong, and other impressions were made. This took MORE time.

K. I came back several times, after the impressions were made, for what was called adjustments. I'd spend a few minutes, for this adjustment, and told that was all that was needed and given another appointment.

L. Dr. Bernstein gave me a choice of three (3) types of teeth that I was to chose one. One style was putried yellow, another, the teeth looked like Dracula's and the third was o.k. for me, but they were entirely too small for my mouth. Dr. Bernstein had taken an early impression of my upper-front teeth for over-bite and correct size for referrence.
** There shouldn't have been any problem on what teeth I should have.

M. There was a continuous disagreement with Dr. Bernstein on what teeth I should have. I wanted teeth the same size as originals and no more. I really got to the "worn-down" position of just getting out of there!! I felt intimidated and coherced into taking what he thought I should have. He kept saying," Don't worry, we'll take care of you". He made remarks that made me feel ashamed to be on GA. I was given the impression that I should be thankful for anything that I get.

N. I informed Dr. Bernstein at least two weeks before that, my Medicaid was to be ended on 14 Oct., 1989, but there was no evidence of concern on their part to meet the deadline. I was told," Don't worry, you still have a 30 day 'Grace Period' to work on". I had no control on appointments.

Page 2 DENTAL

O. I have teeth, (upper plate), that is aligned crooked, unequal in size, shape and number. Uppers do not match lower-partial in size or shape and alignment to uppers.

***** These teeth must be seen and evaluated to be properly considered.

II. SUMMARY;

A. I still have infected teeth that received no care at all.

B. I am stuck with dentures that lack professional commitment.

C. Who would pay for the adjustment for remedying this unethical product/practice? I'm not employed, but on unemployment pay.

D. The continual delay in getting my teeth caused real problems in presenting the proper image for a job interview. I lost jobs!

III. CONCLUSIONS;

A. I really feel that this has been an extreme waste of time and money.

B. My medical symptoms can very well be caused by the dental problems!,

ADDITIONAL MEDICAL and DENTAL PROBLEMS;

A. I'm getting bills and threats of collection on bills that I was given the understanding that Medicaid was to pay. I was never informed of any "over-lap" between HMO and Medicaid.

B. I have NO IDEA what has been paid and what hasn't. I have bills sent me by "billing departments" stating that HMO or Medicaid doesn't pay bill and that I must pay or it will be sent to collections. Is this an attempt to collect twice? How can I tell the difference?

C.Doctor's office personnel not aware of who to send the billings.

D. It seems that I'm caught between "the systems" and my own health at stake.

I'm sent around in a circle when I ask what I should do next. Each "system sends me to another. There doesn't seem tobe any unity. How can someone who is accepted into these programs know what to do?????

E. Doctors and Dentists, (and their office personnel) treat you like your some kind of criminal and they pass judgement on you in terms of evaluating what and if you receive different types of treatment!

F. Patients are not given the same time and attention as "regular clients". The Doctors spend as little time as necessary, and supplement this by sending you to a host of other Doctors. I had to sign a permission form for Dr. Conley before I would receive any treatment. I see this only as "everyone gets a piece of the action"!!!

F. After the Doctors have used up a client's medical-dental help from the State of Michigan, this is evident;

1. The State of Michigan has paid for services that are questionable!
2. The client isn't much better off than when it all started!
3. The only way to have further treatment, for someone not working, is to wait until your accepted back on GA for help. This work, already finished, can't be redone!!!!

DR. IRVING S. BERNSTEIN
DENTIST
145 WEST VIENNA STREET
CLIO, MICHIGAN
TELEPHONE 686-1160

December 5, 1989

Robert Bensinger
11344 West Carpenter Road
Flushing, MI. 48433

RE: ROBERT BENSINGER:
Service Date December 1, 1989. :

On December 1, 1989 our office inserted a upper complete denture and a lower partial denture for you. Your insurance was not in effect on the service date, therefore leaving you with a balance of $395.00 for your upper denture and $425.00 for your lower partial denture a total of $820.00. Prompt payment of this matter would greatly be appreciated. If no payment within seven days from the above date, our office will be forced to turn your account over for collection.

Thank you,

Dr. Irving Bernstein

ISB/deh

BEECHER RD OUTPATIENT RAD.
P.O. BOX 2014
FLINT, MI 48502

TAX I.D. : 38-2493982

12/05/89

ROBERT L BENSINGER
C/O ROBERT L BENSINGER
11344 W CARPENTER RD
FLUSHING, MI 48433

ACCOUNT# 0000050966

BALANCE $186.00
DATE LAST PAYMENT 10/06/89

OUR RECORDS INDICATE THE ABOVE ACCOUNT IS UNPAID. IT IS NOW BEING REVIEWED PRIOR TO BEGINNING COLLECTION ACTIVITY.

IT IS OUR POLICY TO BILL BLUE SHIELD, MEDICARE, AND MEDICAID DIRECT. IF YOU HAVE ONE OF THE ABOVE POLICIES WE NEED YOUR INSURANCE NUMBERS TO FILE A CLAIM.

IF THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, WE WILL NOT BE RESPONSIBLE FOR THE FILING OF ANY INSURANCE CLAIMS ON YOUR BEHALF.

IF THERE IS SOME REASON YOUR ACCOUNT SHOULD NOT BE PLACED IN THE HANDS OF A PROFESSIONAL COLLECTION AGENCY, PLEASE CONTACT OUR REVIEW CLERK WITHIN THE NEXT FIVE DAYS WITH YOUR EXPLANATION HER NUMBER IS (800) 383-1656 IN MICHIGAN OR OUTSIDE OF MICHIGAN THE NUMBER IS (800) 383-1656. OUR BUSINESS HOURS ARE 8:30 TO 5:00 EST MONDAY THRU FRIDAY.

YOUR ASSISTANCE IN SATISFYING THIS PAST DUE ACCOUNT WILL BE APPRECIATED.

VERY TRULY,

BEECHER ROAD OUTPATIENT RADIOLOGY, P.C.

STATEMENT

Borden's Pharmacy, Inc.
415 West Vienna Street
Clio, Michigan 48420
Phone (313) 686-4550

Date SEP. 28 1980 19

Robert Bensinger
11344 W. Carpenter Rd.
Flushing, Mi.

RETURN UPPER PORTION WITH YOUR REMITTANCE

DATE	DESCRIPTION	CHARGES	CREDITS	BALANCE
	Rx			12.25
	No medicaid coverage.			

BEECHER RD OUTPATIENT RAD.
P.O. BOX 2014

FLINT, MI 48502

FORWARDING AND ADDRESS CORRECTION REQUESTED 7985-891

PATIENT NAME	
ROBERT L BENSINGER	
ACCOUNT NUMBER	STATEMENT DATE
0000050966	11-07-89

AMOUNT DUE	AMOUNT PAID
186.00	

Place of Service: BEECHER RD OUTPATIENT RAD.

TRIMED*BR*0000050966
ROBERT L BENSINGER
11344 W CARPENTER RD

FLUSHING, MI 48433

BEECHER RD OUTPATIENT RAD.
P.O. BOX 2014

FLINT, MI 48502

Billing questions? Call: 313\238-1667

PLEASE DETACH AND RETURN TOP PORTION WITH PAYMENT

DATE	DOCTOR	CODE	DESCRIPTION	AMOUNT
08-01-89	CHARLES A KING, DO	71030	CHEST, COMPLETE	68.00
08-08-89	EDWARD MARTIN, DO	71035	CHEST (3) VIEWS	58.00
08-08-89	EDWARD MARTIN, DO	73030	SHOULDER, COMPLETE	60.00

FULL PAYMENT EXPECTED IN 30 DAYS

ACCOUNT NUMBER	DATE OF STATEMENT		AMOUNT PAID	AMOUNT DUE
0000050966	11-07-89	PAYMENTS AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT		186.00

PATIENT NAME
ROBERT L BENSINGER

THIS IS YOUR FINAL STATEMENT, ANY REQUESTED ADDITIONAL STATEMENTS WILL BE $5.00.

MAKE CHECKS PAYABLE TO:
BEECHER RD OUTPATIENT RAD.

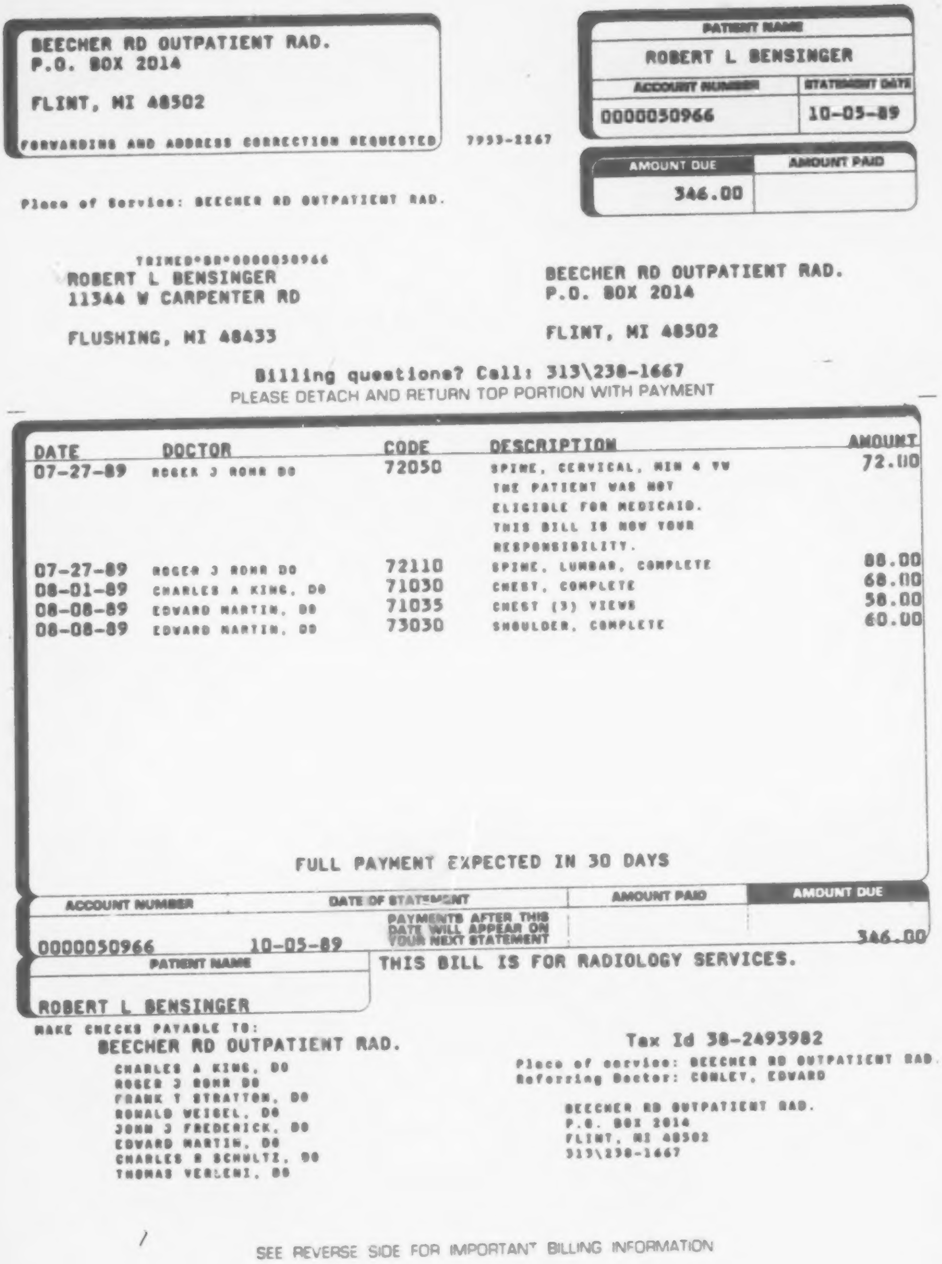
CHARLES A KING, DO
ROGER J ROHR DO
FRANK T STRATTON, DO
RONALD WEIGEL, DO
JOHN J FREDERICK, DO
EDWARD MARTIN, DO
CHARLES R SCHULTZ, DO
THOMAS VERLENI, DO

Tax Id 38-2493982

Place of service: BEECHER RD OUTPATIENT RAD
Referring Doctor: CONLEY, EDWARD

BEECHER RD OUTPATIENT RAD.
P.O. BOX 2014
FLINT, MI 48502
313\238-1667

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION



BEECHER RD OUTPATIENT RAD.
P.O. BOX 2014

FLINT, MI 48502

FORWARDING AND ADDRESS CORRECTION REQUESTED 7953-2267

PATIENT NAME	
ROBERT L BENSINGER	
ACCOUNT NUMBER	STATEMENT DATE
0000050966	10-05-89

AMOUNT DUE	AMOUNT PAID
346.00	

Place of Service: BEECHER RD OUTPATIENT RAD.

TRIMED*BR*0000050966
ROBERT L BENSINGER
11344 W CARPENTER RD

FLUSHING, MI 48433

BEECHER RD OUTPATIENT RAD.
P.O. BOX 2014

FLINT, MI 48502

Billing questions? Call: 313\238-1667
PLEASE DETACH AND RETURN TOP PORTION WITH PAYMENT

DATE	DOCTOR	CODE	DESCRIPTION	AMOUNT
07-27-89	ROGER J ROHR DO	72050	SPINE, CERVICAL, MIN 4 VW THE PATIENT WAS NOT ELIGIBLE FOR MEDICAID. THIS BILL IS NOW YOUR RESPONSIBILITY.	72.00
07-27-89	ROGER J ROHR DO	72110	SPINE, LUMBAR, COMPLETE	88.00
08-01-89	CHARLES A KING, DO	71030	CHEST, COMPLETE	68.00
08-08-89	EDWARD MARTIN, DO	71035	CHEST (3) VIEWS	58.00
08-08-89	EDWARD MARTIN, DO	73030	SHOULDER, COMPLETE	60.00

FULL PAYMENT EXPECTED IN 30 DAYS

ACCOUNT NUMBER	DATE OF STATEMENT		AMOUNT PAID	AMOUNT DUE
0000050966	10-05-89	PAYMENTS AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT		346.00

PATIENT NAME
ROBERT L BENSINGER

THIS BILL IS FOR RADIOLOGY SERVICES.

MAKE CHECKS PAYABLE TO:
BEECHER RD OUTPATIENT RAD.
CHARLES A KING, DO
ROGER J ROHR DO
FRANK T STRATTON, DO
RONALD WEIGEL, DO
JOHN J FREDERICK, DO
EDWARD MARTIN, DO
CHARLES R SCHULTZ, DO
THOMAS VERLENI, DO

Tax Id 38-2493982
Place of service: BEECHER RD OUTPATIENT RAD.
Referring Doctor: CONLEY, EDWARD

BEECHER RD OUTPATIENT RAD.
P.O. BOX 2014
FLINT, MI 48502
313\238-1667

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

called 3:00 pm
6 Feb. 1990

Mrs. Howd

Re; letter -

The meeting for Thurs,
Feb. 8, 1990 at 11:00 AM
IS NOT CONVENIENT!
this is
Robert Bersinger
thank you.

this is my second (2) response to Mrs. Howd, after receiving the papers of 7 Feb, 1990.

A PREPARED STATEMENT

5 February, 1990
mailed (13 Feb, 1990)

TO: Mrs. Howd - Case Worker

I will not verbally or actively do anything that may jeopardize the out-come of the Michigan Dental Association Peer Review, the HMO, Blue Care Network of Eastern Michigan, or the General Assistance Medical Program.

The following people and/or Agencies have been made aware of my particular circumstances;

1. Governor James Blanchard, State of Michigan
2. Senate Majority Leader, Senator John Engler
   State of Michigan
3. C. Patrick Babcock, Director
   Michigan Dept. of Social Services
4. Recipient Unit- Medicaid Program
5. Kevin Seitz, Director, Medical Services Administration
6. Kathleen A. Hersman, Coordinator of Medical Affairs,
   Medical Services Administration
7. Attorney, Robert A. Mucha

I await their decisions on these matters!

Robert L. Pensinger
371-20-1600

NOTE; UP TO THIS DATE, (13Feb., 1990) I HAVE NOT ASKED FOR A HEARING!

[illegible]

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

C. PATRICK BABCOCK, Director

[illegible]

WHO,

will a hearing at this level help?!

Enclosed is a Hearing Summary prepared by the caseworker in response to your Hearing Request.

I did not ask for a hearing.

A Hearing will be scheduled within a short time. Please bring this Hearing Summary with you to the Hearing. You will receive notice of the date and time from the Bureau of Administrative Hearings, Lansing, Michigan.

Genesee County Department of Social Services

These papers were sent to me AFTER my phone response to Mrs. Hard on 6 Feb, 1990.

I was not informed of this!

HEARING SUMMARY
Michigan Department of Social Services
BUREAU OF ADMINISTRATIVE HEARINGS

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

Case Name Bensinger, Robert				
Program 6	Case Number VI3090088A			Date 2-7-90
County 25	District 00	Unit 21	Worker 81	Other ID (As required)

(1) Date hearing requested 1-8-90
(2) Effective date of action 10-14-89
(2) Date client notified of Department action 10-2-89
(4) Deleted pending hearing? ☐ Yes ☒ No

cc Shannon
Sturm
Mr Satire
3101
Glassman

☒ Assistance or Services Actions:
1. Date claimant offered case conference 1-31-90 ~~1-31-90~~ ☐ Accepted ☐ Rejected
2. Date of Administrative review
3. Action(s) prompting hearing request:
☐ Termination ☐ Denied Application 150 ☐ Reduction ☐ Suspension ☒ Other
4. Monthly cost: Before negative action After negative action

☐ Licensing Action(s):
☐ Denial ☐ Refusal to renew ☐ Revocation ☐ Modification ☐ Other

Explanation of action taken and facts and fact sources used in taking action:
Robert Bensinger applied for assistance 5-25-89, with R. Moynihan and was opened for General Assistance and Food Stamps 6-5-89. Client was approved GA Medical. Medicaid was denied due to the fact that client was under 65, was not the caretaker relative of a child under age 18, and was not blind or disabled. Mr. Bensinger filled out DSS Pub. 648-GC, and chose to enroll in Blue Care Network.(HMO).

I was never informed of this – the Provider told me

On 10-2-89 caseworker, Pam Howd, was informed that as of 9-28-89 Mr. Bensinger began receiving UCB Benefits of $366.00 bi-weekly. A prospective budget was done and Mr. Bensinger was determined ineligible for GA and Food Stamps. Closure was entered effective 10-14-89. No extension of GA Medical was possible, as only excessive earned income will allow such a 4 month extension. On 11-2-89, Mr. Bensinger applied with intake worker C. Merriman. On 11-2-89 GA and Food Stamps were denied due to excess income. Medicaid was again denied 11-2-89 due to the same reason prior intake worker denied it on 6-5-89.

On January 4, 1990 a letter was received by the Bureau of Administrative Hearings which has been interpreted as a hearing request. This letter does not complain about any action taken by the county office, or his assistance payments workers. Mr. Bensinger has many complaints about the type of treatment he received from the doctors and dentists from who he sought treatment. This type of complaint is not within the department's authority. Mr. Bensinger has been mailed the phone number of the Office of Inquiry and Concerns. They will refer his complaint to the proper place.

Mr. Bensinger also had complaints that some of the bills he incurred were not paid by GA Medical Program. Copies of these bills were attached to his letter.

Law and Regulation(s) or manual item(s) used in taking action:

I was never informed of this,
and I CONTINUALLY received MEDICAID cards!

Prepared by P. Howd P Howd
Date 2-8-90

PH:tas

Attach a copy of papers to be used at the hearing, INCLUDING MEDICAL INFORMATION where in issue. If licensing action, please attach a copy of the licensing study report. Submit original Hearing Summary WITHIN 15 DAYS of receipt of the hearing request to: DSS, Bureau of Administrative Hearings, P.O. Box 30041, Lansing, MI 48909. DISTRIBUTE one copy of this Summary, with attachments, to claimant/attorney and retain one copy.

DSS 3050 (Rev. 6-82) Previous edition may be used.

1. Dental bill, Dr. Irving Bernstein - $820.00:
   Worker P. Houd has contacted Dr. Berstein's office. This dentist had participated in Blue Care Network but had dropped out. Due to the problems this caused, and Mr. Bensinger's complaints about the dentures, they have given him the dentures, and have decided not to charge him.

2. Beecher Road Out Patient Rad. - $346.00:
   P. Houd has established by phone contact that this bill has been paid through GA Medical.

3. Beecher Road Out Patient Rad. - $186.00:
   P. Houd has established that this is still being processed.

4. Michigan Clinical Lab - $127.50 8/89, $157.50 9/89:
   These bills were rejected, as the Lab is not part of the Blue Care Network

(*) Mr. Bensinger had sent in bills to the Genesee County Office, on November 13 and November 27, 1989. These bills, from Borden Pharmacy (9/89 and 10/89) were also rejected as all prescriptions must be obtained from a Blue Care Network provider.

check these statement out, Trini!

(1.) you did the work on this, and no mention is made of the bill Dr. Bernstein & the collections threat, that was sent me.

(2) you also worked on this, Trini.

(3.) Same as #2.

(4.) Where is this bill coming from NOW?! Dr. Corley specifically SENT ME to this Lab. I sure as hell didn't go on my own!

(*) I've already paid this _myself_! Dr. Bernstein told me to go to this Pharmacy, knowing I was on GA MEDICAL

COUNTY BOARD
[illegible] Crain
[illegible] Hester
John D. Chenis, Sr.

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

C. PATRICK BABCOCK, Director

GENESEE COUNTY
DEPARTMENT OF SOCIAL SERVICES
125 East Union Street
P.O. Box 1620
Flint, Michigan 48502

February 5, 1990

Robert Bensinger
11344 W. Carpenter Road
Flushing, MI 48433

Dear Mr. Bensinger:

RE: V1309998A

Central Office has sent us a copy of the letter they received from you on January 4, 1990.

We wish to inform you that complaints regarding your Medicaid coverage, and treatment by a Medicaid provider, can be directed to the Office of Inquiry and Concerns. Their phone number is 1-517-373-0707.

Because your letter has been interpreted as a hearing request, I must schedule a conference with my supervisor, Mrs. McIntyre, to discuss your case. This has been scheduled Thursday, February 8, 1990 at 11:00 AM. Please contact me if this time is not convenient.

not by me!

Why did she wait until now, to tell me this? RLB

Sincerely,

Mrs Pamela Howd

(Mrs.) Pamela Howd
Assistance Payment Worker
(313) 768-2397

PH:jn

* Note; the attached statement is what I told Mrs. Howd on her answering machine. I had less than two (2) days to meet this appointment! RLB

26 January, 1990

TO WHOM IT MAY CONCERN;

Dear ______________________________

Upon receipt of the letter from the Department of Social Services, (a copy is enclosed), it is apparent that you have not understood my initial letter and documents, sent to you previously.

This letter, (copy enclosed), is merely only a verification of an evaluation made by you which will directly affect me in some way. Pardon me if I sound somewhat negative, but, I am NOW experiencing the same thing that my students told me in a State and Local Government class at Jordan College. We covered various state agencys in our topics, and the verbal responses by the students toward these same agencys desired much to be complimentary. I didn't grasp what they were saying until now. They expressed confusion, anxiety and frustration, knowing that they were ill informed about many things, and that, somehow, they would threatened for payment on situations that were construed to be their fault. They also expressed much fear of retaliation if they made any issue of a bonifide greivance, to the system involved, so they said nothing. ALL these people wrong? I believe, that by sending this letter (enclosed) only will verify some sort of retaliation, fincially or otherwise, on me--later!!!

I must compliment Dr. Weber for his visitation on 22 January, 1990 to visualize my dental complaint. I can only hope for a satisfactory conclussion, however, I really don't expect too much. The enclosed letter only establishes a foundation for further action and DOESN'T address the previous letters I sent to you. I understand the students!

In ALL this communication, you've missed the point. I don't want to point fingers or cause problems, ONLY TO GET SOMEONE TO SEE, that the "system" has forgotten why it exists-- for the people, not the people for the "system". I've said what was needed, and I expect retaliation.

Respectfully,
Robert L Bensinger

Robert L. Bensirger
11344 W. Carpenter Rd.
Flushing, MI 48433

P.S. Why should the deserving clients of Social Services be treated like the few violators? I should be like the others, and look the other way so I can't see the State of Michigan "ripped off". I love my state!!!!!

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor
DEPARTMENT OF SOCIAL SERVICES
300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909
C. PATRICK BABCOCK, Director

January 31, 1990

Mr. Robert L. Bensinger
11344 W. Carpenter Rd.
Flushing, Michigan 48433

Dear Mr. Bensinger:

Mr. Seitz has asked that I respond to your letter concerning dentures provided to you by Dr. Irving Bernstein.

Our dental consultant has met with you and reviewed dental records obtained from Dr. Bernstein. He has decided to refer your complaint regarding your dentures to the Michigan Dental Association Peer Review. That office will contact you directly regarding this matter.

I trust this information will be of assistance to you.

Sincerely,

Kathleen A. Hersman

Kathleen A. Hersman
Coordinator of Medical Affairs
Medical Services Administration

KAH/jhm

This is why I'm against any hearing with Mrs Howd (and who ever), until this has been finalized! RLB

5 February, 1990

Kathleen A. Hersman
Coordinator of Medical Affairs
Medical Services Administration
Department of Social Services
300 South Capitol Avenue
P.O. Box 30037
Lansing, MI 48909

Coordinator,

I thank you for your kind letter of Jan. 31, 1990, and the help Dr. Weber has given me . However, I am very reluctanct to be too enthused about this because of past results. All I can say is that," All I wanted in the first place was an honest and professional approach to my dental problems. (Please read early letter). If these "professionals" couldn't "do right" by me in the first place ,(Who knows how many other clients like me), how could I expect any different? NOW! Medical too!!!!!

MS Hersman, all this attention to the Dental aspect of original complaint, has completely over-looked the same situation with the medical attention I received. As I've stated before, after all the testing I was put through, I still have the same symptoms. Nothing has changed. If the system is getting billed for services that are not relavent to the symptoms, how can this be allowed to be valid? I noticed the articles in the paper, explaining the symptoms of LYMES DISEASE, and they are identical to mine. I'm not saying that I have Lymes Disease, but I told Dr. Conley that I saw the initial "ring and center" of Lymes, it was supposed to have been checked, because Dr. Conley said that nothing was evident in this and other similar symptoms. I'm not some kind of "leech" on society, just wanted to be healthy.

Respectfully,

MR. ROBERT L BENSINGER
11344 W CARPENTER RD
FLUSHING, MI 48433

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor
DEPARTMENT OF SOCIAL SERVICES
300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909
C. PATRICK BABCOCK, Director

February 13, 1990

Mr. Robert L. Bensinger
11344 W. Carpenter Road
Flushing, Michigan 48433

Dear Mr. Bensinger:

Thank you for your letter of February 5, 1990 concerning your medical care.

Complaints regarding medical care should be directed to the Michigan State Medical Society at the following address.

Genesee County Medical Society
806 Tuuri Place
Flint, Michigan 48503

I trust this information will be of assistance to you.

Sincerely,

Kathleen A Hersman
Kathleen A. Hersman
Coordinator of Medical Affairs
Medical Services Administration

Is she taking over for you? This is confusing enough!

KAH/jhm

Who are these people?
These Agencys are NOW
coming out of the walls!
What should I do on this, Trini?

STATE OF MICHIGAN
JAMES J. BLANCHARD, Governor
DEPARTMENT OF SOCIAL SERVICES
300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909
C. PATRICK BABCOCK, Director

January 24, 1990

Mr. Robert L. Bensinger
11344 W. Carpenter Rd.
Flushing, Michigan 48433

Dear Mr. Bensinger:

Governor Blanchard has asked that I respond to your letter of January 4, 1990 concerning your medical and dental bills.

Records indicate that you were eligible for General Assistance Medical from May 25, 1989 through October 31, 1989. On August 1, 1989 you were enrolled in the HMO, Blue Care Network of Eastern Michigan. With the exception of emergency treatment, all of your medical care was to be rendered by the HMO or by a provider you were referred to by the HMO.

The medical bills enclosed with your letter are for services provided to you during your enrollment in the HMO. (Note: July 27, 1989 dates of service have been paid.) These services cannot be billed to the General Assistance Medical Program. If you did not receive a referral from the HMO, payment of the bills will be your responsibility. You may wish to discuss this matter further with the HMO.

SEE WHAT I MEAN!

NO ONE HAS TOLD ME OR HAS INSTRUCTED ME IN ALL THIS TIME!
RLB

Your dental complaint is being reviewed by our dental consultant. Ms. Kathleen A. Hersman, of my staff, will advise you in the near future of the results of his review.

I am hopeful that this information will be of assistance to you.

Sincerely,

Kevin L. Seitz, Director
Medical Services Administration

COUNTY BOARD
[illegible]

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor
DEPARTMENT OF SOCIAL SERVICES
C. PATRICK BABCOCK, Director

GENESEE COUNTY
DEPARTMENT OF SOCIAL SERVICES
125 East Union Street
P.O. Box [illegible]
Flint, Michigan 48502

December 7, 1989

Robert L. Bensinger
11344 W. Carpenter Road
Flushing, MI 48433

Dear Mr. Bensinger:

RE: Case # V1309998A

Your letter of November 22, 1989, was forwarded to me for review. The reason the state will not pay for the prescriptions you received from Bordens Pharmacy is because you were enrolled as a Blue Care Network patient, as your GA medical card clearly indicated, and Blue Care Network should have provided all of your medical care, including prescription services, through their clinic and pharmacy.

You were not eligible for medical or prescription services from any physician or pharmacy other than Blue Care Network. If you obtained such services from sources other than Blue Care Network, you are responsible for payment of the associated bills.

If you have any further questions concerning this matter, please feel free to contact this office.

Sincerely,

Jeffrey R. Garner, Supervisor
AP Information & Referral Services
G.C.D.S.S.

JRG:jn

This is still another voice heard from! How many agencies have I got to deal with, OR get "stone-walled" by!? You have been the only one to help me, Toni! thank you - very much! RLB

16 February, 1990

Dept. of Social Services
Client Medical Assistance
Medical Services Administration
300 South Capitol Avenue
P.O. Box 30037
Lansing, MI 48909

Attention Trini J. Dixon,

I want to thank you for all your kind help and consideration in this maze of problems that I have over the past months. I can't help being concerned, now, because there is so much conflicting paper-work coming in on me. I'm sending you copies of all these letters I've received since last we communicated. I can't beleive this is happening!

I want to make it clear, that, I don't want anyone's job, cause any hard feelings, or hurt people's careers. ALL I wanted in the first place, was to find what my medical problems were, and correct them. In the dental part, I'd lived with enough pain and infection that any help would really be appreciated. However, after going through all those months and STILL have the medical problems, the dental problems, and all this added threatened collections for unpaid bills, that I was told would be taken care of by GA and/or, Medicaid and or, HMO. I never had any idea that I would have to defend myself against someone's help!

You know Trini, I've experienced people in these Doctor's offices, that weren't all that sure of what card applied to what service, and how to present the billing. This is not amazing to me, after I asked Case Workers what Medical Agency covered what services- and they weren't sure, so I'm referred to the Provider, who tells me that Medicaid covers all the services. I receive a HMO card, weeks after I had already started Medical and Dental services. Then they didn't spell my last name correctly; Beneinger. I went in to HMO offices to correct this- I never did get a corrected card. I was told that my HMO card was only good for the prescriptions from Dr. Conley. I assumed that Medicaid covered the rest. I was using Medicaid cards throughout this ordeal, and the only clarification I received was; about 3 months into Medical and Dental care, there was printed on the Medicaid card- For Dental Use only- or such like. It has been one great big, continuous state, of confusion with me inbetween.

Sincerely,
RLBensinger

MR. ROBERT L. BENSINGER
11344 W CARPENTER RD
FLUSHING, MI 48433

Thanks for the 2 booklets on medicaid = they were best
[illegible] not!

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909

C. PATRICK BABCOCK, Director

February 8, 1990

Mr. Robert L. Bensinger
11344 West Carpenter Road
Flushing, Michigan 48433

Dear Mr. Bensinger:

This office received your letter regarding services from Beecher Road Outpatient Rad. and Irving S. Bernstein, D.D.S.

Beecher Road Clinic and Dr. Bernstein did accept you as a Medical Assistance recipient, therefore, they will bill the Michigan Medical Assistance Program directly.

You may be billed for services, if providers advise you prior to services being rendered that you will be responsible for payment.

Enclosed are a couple of pamphlets for your convenience. Hope this will be helpful to you.

Sincerely,

Trini J. Dixon

Trini J. Dixon
Client Medical Assistance
Medical Services Administration

Enclosure

cc: Beecher Road Outpatient Rad.
Irving S. Bernstein, DDS

TJD/jhm

Mr. Riegle: Feb. 13, 1990

I am a 32 yr. old woman who is & has been a wheelchair user for over 15 years. I can't express the need for the expansion of Medicaid or some kind of nationwide medical coverage. I urge your support of any such ~~problems~~ proposals.

During my 15 yrs. in a wheelchair, I have had many problems with Medicaid & would like to share with you - by the way, my income has never been over $400 a month (SSI):

1. accident in Canada - ambulance, stitches X-rays, tetanus shot, & a totaled wheelchair - Medicaid covered nothing

2. Medicaid has chosen not to cover Valium which I have to take on a daily basis to control spasms, I have to take the generic form because I can't afford $35 a month.

3. I broke my finger & wasn't sure if this was considered what Medicaid terms as an "emergency," so here I sit with a crooked finger.

4. I have been waiting for Medicaid approval since Oct. for my chair which needs many repairs.

5. Pnemonia & pleurisy sent me to the hospital for oxygen, but even though 2 doctors said I should stay, the admitting doctor sent me home as soon as she found out all I had was

Medicaid- but never said this was "why" - just sent me home alone with painkillers & a need for 24 hour care- Medicaid didn't cover this - I sometimes wonder how I lived.

The stories go on & on, but the need for Medicaid expansion is much needed & hopefully it will come before I have to find another doctor who accepts Medicaid- there are so few!

Mary Lou BARANSKI

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Committee on Health

Senator Donald W. Riegle, Jr.

Sign In Name: DOROTHY KAZMAN

Address: 24488 GREEN HILL

WARREN MI 48091

Representing:

****

I invite you to attach a prepared statement or to submit your written testimony:

Dear Senator Regal :

I was covered for Blue Cross & Blue Shield frey Acme Precision for lifes + worked their 27 yrs, that was in a Trust fund. In June 1989, there was no payment to Blue Cross they said they were bankrupt, now I have to pay $1.24 dollars every 2 months, plus they hold back $.39 dollars, for medicare. I can't afford this out of $717 dollars income, time I pay rent taxes and other bills I don't have much left for myself. Whats the use of living if you can't have a little to spend on yourself. I've been a widow for 16 yrs, nothing but struggling to live. I think Pres. Bush should give more to us because we struggled all our lives to make a better Country to live in. There are plenty of people in their 50's that have NO insurance and don't earn more that five dollars an hr. (over)

We had depressions, wars recessions and didn't work for the Big Three to get all our benefits paid for. What kind of a life is it when you can't enjoy anything because there isn't enough money just barely pay my way.

I have health problems. I have to pay for my prescriptions and a few dollars for office call.

I am one of the senior citizens on the Warren advisory board. I wish something could be done for people that are in the same boat as I am. Thank you for being concerned.

Dorothy Kazman
24488 Greenhill
Warren Mi. 48091

24 FEB 1990
22913 GLENBROOK
ST CLAIR SHORES, MICH. 48082

SENATOR D. RIEGLE
U.S. SENATE BLDG
WASHINGTON, D.C. 20510

DEAR SENATOR RIEGLE:

AS AN OBSERVER/ATTENDEE AT YOUR RECENT WARREN MEETING, REGARDING THE PROMOTION OF A GOVERNMENT-SPONSORED HEALTH PLAN FOR ALL AMERICANS, I OFFER THE FOLLOWING COMMENTS FOR YOUR EDIFICATION AND PROMPT LEGISLATION ACTION.

THE CASE OF CROHN'S DISEASE WHICH AFFECTED MS CHIRLY EICHLER, WHO DIED FROM THE LACK OF FUNDS AND MEDICAL TREATMENT, WAS THE RESULT OF A BENIGN NEGLECT AND INSENSITIVITY IN THE CARE OF OUR COUNTRIES NEEDY. I REALIZE THAT CONGRESS PLACES PRIORITIES ON SUCH EVENTS AS FUNDING DRUG WARS, ARCHAIC GOVERNMENTS IN CENTRAL AMERICA, B2 STEALTH BOMBER PRODUCTION, ETC., CAUSED BY THE MEDIA DISTRACTION FROM PEOPLE NEEDS, IS FRANKLY OBSCENE TO SAY THE LEAST.

A RECENT GALLUP POLL SHOWED A REMARKABLE INCREASE IN SUPPORT OF THE IDEA OF A SOCIALIZED MEDICINE. 73 PERCENT FAVORED HAVING THE GOVERNMENT PROVIDE FREE HEALTH CARE TO ITS CITIZENS, EVEN IF IT MEANT WAITING A SHORT-TIME TO RECEIVE HEALTH CARE. OTHER POLLS SHOW 75 PERCENT

RECEIVED MAR - 1 1990

IN 1968, 1975 AND 1978 TO 1986 AND INCREASED TO 90 PERCENT IN 1989. NOW WHAT COULD BE MORE REVEALING TO YOU, SENATOR RIEGLE, THAN SUCH STATISTICS TO SUBMIT YOUR COMMITTEES RECOMMENDATION TO CONGRESS MARCH 1, 1990.

I ALSO REALIZE THE ROOT OF PASSING SUCH LEGISLATION THRU CONGRESS WILL COME FROM THE (MEDIGAP) INSURERS INDUSTRY WHICH WILL (THEY) BASH "SOCIALIZED MEDICINE" TO STAY IN BUSINESS. THEY HAD USED CONSIDERABLE INFLUENCE IN THE CASE WHICH CAUSED SENATOR ED KENNEDY TO SUBSTITUTE HIS ORIGINAL HUMANE PROPOSAL, IN THE MID-1970, FOR A MAJOR ROLE FOR THE INSURERS. IT IS A KNOWN FACT THAT THE INSURERS TAKE APPROXIMATELY $150 BILLION OR $25 OUT OF EACH $100 CONTRACT OF THE NATIONAL HEALTH CARE EXPENDITURE WHICH TOTALS AROUND TODAY AT $600 BILLION. THIS FACT IS DERIVED FROM DR. THOMAS BODENHEIMER'S PAPER PRESENTED AT THE AMERICAN HEALTH ASSOCIATION CONVENTION LAST OCTOBER 1989.

IT IS HOPED THAT THE ABOVE WILL SERVE A USEFUL PURPOSE AND BECOME PART OF YOUR COMMITTEES RECOMMENDATION. NOTHING IS MORE IMPORTANT IN OUR NATIONS CONCERN IS THE SURVIVAL HEALTH PROTECTION FOR ALL AMERICANS, AND ELIMINATE THE SAD STORIES AS REPORTED BY MRS EICHLER' CASE. FURTHER WE ARE, WITH SOUTH AFRICA, THE ONLY WESTERN NATION LACKING NATIONAL HEALTH CARE.

RESPECTFULLY
George Clark

STATEMENT OF THE SOUTHEAST MICHIGAN HOSPITAL COUNCIL

The Southeast Michigan Hospital Council appreciates the opportunity to provide written testimony to the Senate Finance Subcommittee on Health for Families and the Uninsured.

The health care community in southeastern Michigan is very much interested in resolving the problems of providing health care to the uninsured. It is critical that all Americans have access to high quality, affordable, and adequately financed health care services. We cannot afford to continue to erode our standard of care and access to care because of inappropriate shifting of the expense of caring for the uninsured to a health care system financially unequipped to shoulder this responsibility. It is past the time when our nation should have come to grips with the need to ensure access to necessary health services for all Americans. We ensure a right for all Americans to obtain education through high school but no corresponding right to basic health services exists.

Proposed solutions to the problem of healthcare for the uninsured should include strategies that maximize private and public coverage through expansion of public programs and employer participation in provision of reasonable health benefits for their employees. Furthermore, health care providers, public sector representatives, purchasers, insurers, and consumers should be involved in defining what is a necessary basic health benefit package for all Americans. Along with defining a reasonable benefit package must come an agreement that healthcare service providers will receive fair payment for necessary services rendered to people in need. Fair payment should be based on a clear definition of what constitutes an efficient and effective healthcare service provider. Subsequently, recognition as an efficient provider should bring with it full payment for the cost of providing the care from both the public and private sectors. The present public programs (Medicare and Medicaid) have a benefit package that is inadequately financed and has increasingly shifted the cost of providing care to a healthcare system which is financially unable to sustain this burden. In 1988, the Medicare program provided southeastern Michigan hospitals with an estimated $106 million less than what it cost to provide services. Our hospitals also received an additional $76 million less than what it cost to provide care to the poor under Medicaid and provided an additional $200 million worth of services to the medically indigent for which no payments was received.

As coverage is being expanded, the public sector must also allow healthcare providers to meet the challenges of delivering affordable health care services in a flexible manner which allows hospitals in particular to respond to the changing healthcare environment.

Insurance market reform efforts must have built-in mechanisms that ensure appropriate financial viability for those insurance programs. This is necessary to ensure that patients and providers are protected against unsafe insurance practices.

Cost Containment efforts must include recognition of: the medical liability problem; the burgeoning elderly population; new technology; costly treatment of AIDS, heart disease, cancer and other chronic diseases; the cost of defensive medicine; and the need to replace aging healthcare facilities. These are problems that require national public policy decisions and sufficient accompanying resources.

Finally, we propose that all Americans be provided basic health coverage although we are not suggesting everyone have the same benefit coverage, that the financial mechanisms for financing this coverage be both publicly and privately financed, that the program provide fair payment to efficient and effective providers, and that incentives be created that encourage and reward efficiency. The Southeast Michigan Hospital Council is prepared to assume an advocacy role and to work in gathering support in conjunction with other organizations to develop and implement health policies that address the needs of the uninsured. We are proud that our Senator Reigle is providing the necessary national leadership on this growing matter of concern to all Michiganians and all Americans.

STATEMENT OF THE U.S. SMALL BUSINESS ADMINISTRATION

INTRODUCTION

In the State of the Union Address the President asked the Secretary of Health and Human Services to conduct an overall assessment of the quality, accessibility and cost of our nation's health care system. That overall assessment has already begun in the Domestic Policy Council process. As that review proceeds, I would like to make a few comments about the effects of health benefits on small business.

Health benefits are of paramount importance to owners and employees of small business. owners recognize that to compete in today's labor market, they must develop competitive compensation packages which both attract and keep able workers. Recent data seems to indicate that more small business workers are receiving insurance coverage.

Generally, the ability to offer health insurance turns on profitability—if the business does not have sufficient profits, it cannot offer health insurance. However, some companies have mentioned to me that they are priced out of the health insurance market, or are in the type of business in which health insurance is not available, or that waiting periods for new employees are such that they are unable to attract the type of workers needed.

As a result, it is very important to focus on particular attributes of small business and its work force, as well as on the extent of health care cost and coverage for small business.

I also believe that recent movements toward insurance reform in the small business market, particularly by the health insurance industry itself, is a necessary first step toward expanding access to coverage among uninsured workers and owners. It is critical for the health insurance industry to reasonably price policies for small business and to offer a variety of lower cost products.

At another level, the health of the economy is closely linked to the health and growth of the small business sector. New and small firms have been responsible for the lion's share of net new Jobs. In fact, SBA's economic research office estimates that small firms (those with fewer than 500 employees) created two-thirds of the new Jobs added between 1980 and 1986. Any proposed health care reforms, thus, must be sensitive to the interplay between the health of the economy and the health of small business.

We have very serious concerns about proposals that mandate universal health insurance coverage through employers. The cost of these programs would strain employer-employee relationships, and adversely affect hiring patterns of existing companies while increasing start-up costs for new employers.

Also, with the internationalization of the American economy, small businesses are expanding to the more volatile world markets. Therefore, it is important that small business flexibility not be unduly restricted by mandated health insurance. Firms must have the ability to remain responsive to changes taking place in the 1990s and beyond.

WORK FORCE CHARACTERISTICS OF SMALL BUSINESS

Small firms are more labor intensive than large firms—they typically depend more on people than machines. Labor intensive businesses, particularly the service sector, are projected to provide most of the U.S. employment growth in the next decade. Furthermore, in the service sector, compensation—including benefit costs—is a higher proportion of production costs for small firms than for larger ones.

Small firms also have a mix of workers that is different from their larger counterparts. They tend to hire younger and older workers, women, part-time workers and workers who frequently change Jobs. These characteristics result in greater expense for health care protection.

New data from the 1988 Current Population Survey provide a basis from which to compare how workers differ by firm size.[1]

- Because the teenage population and the labor force shrank between 1983 and 1988, the proportion of younger workers in firms of all sizes dropped sharply. Small firms employed 61 percent of the younger workers, a decrease of more than 5 percentage points from 1983. The decline was greater for small firms than large, in part reflecting the growing competition for entry level workers.
- In 1988, 80 percent of elderly workers were employed in small firms—the same percentage as 1983.
- Women were more likely to work in small firms than large in both 1983 and 1988. About 58 percent of all women workers were employed in small firms in 1988—a drop of only one percent from 1983.
- Small firms have higher labor turnover rates than large firms—partly because of the kinds of workers they hire and the opportunities they provide for flexible

---

[1] Unpublished data from the May, 1988 Current Population Survey, Office of Advocacy, U.S. Small Business Administration, 1990.

work conditions, including part-time, part-year Jobs. About 27 percent of workers in small firms move every year compared with 15 percent in large firms.[2]

- Part-tee employees (those working fewer than 35 hours per week) were more than 20 percent of the small firm work force in 1988, compared to 13 percent in large firms. This compares to almost 30 percent in small firms and almost 20 percent in large firms in 1983. Declines in part-time employment in firms of all sizes during this time were due to continued economic expansion.

What do these work force characteristics mean for employers who offer health insurance? They affect whether a worker is eligible for health insurance; whether this person, if eligible, participates in the plan; and the eventual cost of health insurance to the worker and his or her employer.

For example the profile of a typical ineligible worker that can be gleaned from analysis of the 1988 Census data is a young, unmarried, low-wage, part-time employee in a service occupation in the retail or contracting sector who has worked for his employer less than a year.

Overall, younger workers tend to be less interested in health insurance than older workers. Older workers, who place a priority on health insurance, may not participate because the costs are prohibitive. Women workers who are heads of households are more likely to participate, but women who are secondary workers are frequently covered by a spouse's plan and will not participate in their employer's plan.

SMALL FIRMS AND HEALTH CARE COVERAGE

Studies conducted for SBA show that firms with 1-10 employees are those least likely to have health insurance. These firms probably do not generate enough profit to afford coverage.[3] Follow-up reports indicate that small firms which did not offer health insurance during the period of our earlier studies began to offer health insurance when they had substantial increases in revenues and employees.[4]

Besides profitability, the size of a firm consistently constrains health care coverage. An examination of the 1988 Current Population Survey (CPS) conducted by the Bureau of the Census shows that the lower rate of health care coverage in small business has remained constant. These new CPS data indicate that 81 percent of all wage and salary workers were offered health insurance by their employers, but, only 42.2 percent of workers in firms with 1-9 employees were offered health insurance. The offer of coverage rises consistently with size of firm; 93.1 percent of all wage and salary workers in firms with more than 100 employees are offered insurance. It is important to note, however, that the offer of health insurance does not necessarily equal coverage.

The number of insured workers in firms with 1-24 employees actually increased in the past ten years, with 36.3 percent covered in 1979, increasing to 39.2 percent by 1988. This increase may be a signal that business is raising the stakes in competition for the types of workers traditionally employed by small business.

Although everyone has suffered from skyrocketing health care costs, health care premiums for small companies run 10 to 40 percent higher than for large firms. Medical underwriting, administrative costs, and the inability to self-insure increase small business health care costs dramatically. Unlike large plans, a catastrophic claim has a major effect on a small employer's policy, and can result in the insurer either canceling the policy or increasing the cost, making it unaffordable.

WHAT DOES SMALL EMPLOYER HEALTH CARE COVERAGE LOOK LIKE?

When health insurance is offered, how do small employers treat the eligibility of their workers? Our studies show that small firms with health benefits more frequently offer coverage to all employees than do large firms. About 44 percent of small firms (with fewer than 100 employees) versus less than 25 percent of large firms (with more than 100 employees) indicate that all employees are eligible for health insurance coverage, though more employees actually refuse coverage in small firms than large firms.

Part-time and seasonal workers in small firms are also more likely to be offered coverage. Seventy-six percent of part-time workers and 59 percent of seasonal and temporary workers are excluded from health plans, compared with 68 percent and 49 percent, respectively, in small firms.

---

[2] Berkeley Planning Associates, *Labor Turnover and Worker Mobility in Small and Large Firms: Evidence from the SIPP* (Washington, D.C.: U.S. Small Business Administration, Office of Advocacy), December, 1988.

[3] ICF, Incorporated, *Health Care Coverage and Costs in Small and Large Businesses*, (Washington, D.C.: U.S. Small Business Administration, Office of Advocacy), April, 1987.

[4] Lewin/ICF, *Increases in Health Insurance Coverage Among Small Firms, 1986-1988,* National Association for the Self-Employed, June, 1988.

Small employers are also more likely to pay all health premium costs rather than require some employee contribution. Seventy percent of firms with fewer than 100 workers pay all of their employees' single premium contracts, compared to 61 percent of firms with more than 100 workers. On average, the smallest firms pay 89 percent of single premiums and about the same for family premiums, while firms with more than 500 workers pay 87 percent of single premiums and only 67 percent of family premiums.[5]

For these small firms that offer coverage, providing more complete coverage than larger companies makes sense; it may be less of an administrative headache to do so, or it may compensate for providing fewer fringe benefits overall. It may also be attributable to the fact that they employ family members.

STATE MANDATED BENEFITS AND SMALL BUSINESS

Since full service plans similar to those in large companies are offered to protect employers and their employees against substantial risks and to retain and attract employees, small business owners prefer full service plans. Small employers' choice of benefit packages, however, is limited to more inclusive plans because state legislation often prescribes the content of health insurance purchased from commercial insurers and Blue Cross/Blue Shield plans. These mandates may require specific services or require specific reimbursement of specialty providers' services.

By increasing mandated coverage, premiums rise to reflect added services, and have a substantial effect on small business insurance rates. Employers cannot offer basic medical plans to protect themselves and their employees from risk; but must include all mandated services if they offer insurance at all. As a result, state mandated benefits is one of the primary reasons that firms self-insure. Under ERISA, these firms are not considered insurance companies regulated under state law, and therefore are not required to offer state mandated benefits.

According to the Health Insurance Association of America (HIAA), health insurance mandates decrease the likelihood that a small firm will offer coverage to employees, and increase the probability that a medium or large size company will self-insure. HIAA estimates that each new mandate enacted between 1982 and 1985 lowered the likelihood that a small firm would offer coverage. Their report also estimated that 51 percent of firms that converted to self-insurance between 1989 and 1984 would not have done so had there been no mandates.[6]

The full burden of state mandates on small firms can be better appreciated when one reviews those who are not required to offer state mandated benefits. In addition to self-insured firms, which employ approximately 70 percent of workers in firms with 1000 or more employees, and 30 percent in firms with 100–999 employees, Federal employee plans, Medicare, Medicaid, and often state government employee plans are also exempt from state mandates.

Developments in the states of Washington and Virginia, which limit the requirement of state mandates for small firms, should be applauded. Washington state is trying an experiment to exempt firms with 25 or fewer employees from 19 state-mandated benefits. Virginia also waived mandates to permit Blue Cross and Blue Shield to offer lower cost plans containing certain maternity and well-baby benefits. Employers with 50 or fewer employees that did not offer health insurance in the previous 12 months would be eligible.

It is unlikely that allowing basic plans without mandated requirements would undermine essential coverage. Small businesses often cover families that work together, and health benefits are very important for recruiting and retaining employees. As a result, a business committed to buying insurance will purchase a plan that satisfies the needs of its workers and owners.

STATE AND LOCAL INITIATIVES

In December 1988, SBA's Office of Advocacy issued a report on the variety of state and local initiatives expanding health insurance coverage.[7] These plans are Just now to the point that we are getting very good information on what works and what doesn't for very small firms.

---

[5] ICF Incorporated, *op.cit.,* p. IV. 13.

[6] Jon Gabel and Gail Jensen, "The Price of State Mandated Benefits," *HIAA Research Bulletin,* July, 1989.

[7] Expanding Health Coverage in Small Business: State and Local Initiatives, Office of Advocacy, U.S. Small Business Administration, December, 1988.

I believe that these approaches should be carefully evaluated when their effectiveness can actually be measured. *The Robert Wood Johnson Foundation*—sponsored plans particularly target the firm size that most needs insurance and has the most access problems—those firms with 1-5 employees, and the self-employed.

CONCLUSION

There is no question that small employers will have to address the issue of access to health care, especially as the labor demographics change. Competition for workers increases the importance of employee benefits, such as health insurance, in order to attract and retain workers, and an aging work force increases the overall demand for coverage.

Our voluntary system for employee benefits has worked well overall. Now the emphasis should be on removing barriers to affordable health insurance products and access to such products by the very small firms, so that this voluntary system can work for the sector of the economy which best provides the impetus for economic growth.